CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 58 JANUARY, 1943 NO. 1

California and Western Medicine

Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco
Phone DOuglas 0062

Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . . GEORGE H. KRESS

Committee on Publications

George W. Walker (Chairman) . . . . . Fresno 1943
F. Burton Jones . . . . . Vallejo 1944
Francis E. Toomey . . . . . San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON
Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS

RECENT MEETING OF PACIFIC STATES PROCUREMENT AND ASSIGNMENT SERVICE COMMITTEEMEN

Session of National, State and Local Procurement Officers.—Commencing Tuesday, January 12th, an important session of Procurement and Assignment Service committeemen of the ninth army corps area and the 11th and 12th naval districts, representing the professions of medicine, dentistry and veterinary medicine, met at the Sir Francis Drake Hotel in San Francisco, to confer with the representatives of the Washington office of the Procurement and Assignment Service of the War Manpower Commission (Doctors Harold S. Diehl and Max E. Lapham), and consider procurement problems that have arisen in the areas mentioned.

Only those members of the medical profession who have had responsibilities in this work can appreciate the many worries that have beset state and local procurement representatives, as succeeding directives from headquarters at Washington, D. C., modified or nullified prior instructions. Since the judgments of state and local procurement committees, in relation to decisions on whether individual physicians, should or should not apply for commissions with the Armed Forces, may have good or ill influence on the future careers of many physicians, it is only natural that the procurement committeemen should desire explicit instructions that can be carried out in impartial and impersonal manner.

It is not possible to give a transcript of the many phases of procurement work which received comment or discussion. As the meeting progressed, the impression early became evident that all the committeemen in attendance were earnest in their desire to do everything within their power, in order to provide medical personnel in quality and number that would make possible, adequate medical care for all citizens, not only for those attached to the Armed Forces but also to those who have civilian status.

* * *

Some of the Information Brought out in the Meeting.—Without further comment, note is made in the following paragraphs of some of the statements by various speakers, with special reference to our California problems. As new instructions are received, the State procurement officers and their local committeemen probably

will be in position to amplify or clarify some of the following announcements:

The establishment of state quotas was not an easy matter. The political-geographical units were deemed best to follow, rather than trade or community areas, even though, in special instances, the latter might have provided a more accurate background concerning medical needs.

Looking backward, it is a question whether the recruiting teams of the Army, which were established in some of the States, were a real asset in the work. So much depended upon the tact and efficiency of the medical officers in charge. The recruiting teams have been discontinued in all but five states, and it is planned to give up that service altogether.

The medical departments of the Army and Navy are relying more and more upon the recommendations of the State Procurement and Assignment officers. So much so, no physician will be given a commission unless certified to as available by the proper Procurement Board.

Procurement and Assignment service, for the time being, will be limited to 21 states; the other commonwealths, up to the present time, having filled their quotas.

The heavy enrollment of medical officers during the year 1942, greatly depleted the pool of available physicians, for present and immediate future needs.

The A.M.A. roster of 1941, based on its questionnaire of that time, indicated that 176,000 physicians were in active practice in the United States. Certain deductions were necessary to secure a figure that would represent a more accurate pool of medical men who could be utilized to supply needs of the Nation for medical services. Deductions included such items as: loss through death; full-time employees of state and local health departments; hospital administrators; teachers in medical schools; hospital residents; ineligibility because of physical disabilities; efficiency deductions as higher age brackets were reached.

When all deductions were made, it appeared that the total pool of physicians available for military service and civilian practice, on October 1, 1942, approximated 136,000, instead of 176,000.

In the Armed Services, up to November 1, 1942, the enrollment of physicians in the Medical Corps of Army and Navy was 40,945.

With quotas based on the proportion of one physician to 1,500 citizens—the figure used as a base in the calculations—it was found that after deductions had been made, the total number of physicians who could be construed to be available for military service was 52,400, of which number 40,945 had been enrolled up to November 1, 1942; thus leaving a total of 11,455 Doctors of Medicine still available for all branches of the Armed Forces.

The tables of organization for medical officers, as established by the Army and Navy, are construed to be the ideal ratios. It is held that these ideal tables should stand, even though the Surgeon Generals may find it necessary to make modifications or adjustments, in view of the limited number of physicians still available. Thus, while under the ideal tables a total of some 30,000 additional enrollments of physicians might be needed for the Armed Forces, the military authorities will reduce that figure to some 11,000, in order that civilian needs for medical services shall also be met. In other words, at the present time, both the Armed Forces and the civilian population will be obliged to accommodate themselves to a lesser number of physicians than those indicated in the accepted tables, and to the overall ratio of about one physician to 1,500 persons.

The Army and Navy have come to a mutual understanding concerning the proportion each service will take from the pool of 11,455 physicians who are construed at the present time to be available for military service.

Procurement and Assignment officials at Washington hope the 1943 recruitments will be made prior to November 1st, preferably in monthly allotments, to permit the Washington authorities to make proper tabulations for the calendar year.

The California quota, from December 1, 1942 to the end of 1943, is estimated as 1,139 physicians still to be enrolled. It is estimated that these physicians should come approximately from the following districts: Bay Region (San Francisco, Alameda, Contra Costa and Solano Counties), 345 physicians; Los Angeles (Los Angeles and Orange Counties), 761 physicians; remainder of California, 33 physicians.

It was stated that if a physician, construed to be essential in industry or civilian practice, left such a place of his own volition, to take up practice in some other community, it would be proper to certify him, in his new location, as being available for military service.

The problem, of who and how many physicians should be declared essential in certain war industries, is now a subject of earnest study.

On December 1, 1942, California was credited with a total enrollment of 2,266 physicians enrolled in the Armed Forces.

CALIFORNIA'S MEDICAL PRACTICE ACT—ARE TEMPORARY LICENSES TO PRACTICE DESIRABLE?

Early Correspondence.—On September 26th last, the C.M.A. Council, through its chairman, Captain Philip K. Gilman, took up with the California State Council of Defense, special consideration of the presumable "shortage of trained medical aid."

If a "doctor shortage" does exist in the State, the California Medical Association, through its constituted officers, wishes to take steps necessary to provide adequate medical care for citizens. Council Chairman Gilman's letter of September 26, 1942, outlines the problem, and for the information of C.M.A. members, appears below.

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

September 26, 1942

Sub-Committee on Health of
Emergency Medical Service,
California State Council of Defense,
Bertram P. Brown, M. D., Chief,
995 Market Street,
San Francisco, California.

Dear Sirs:

Your letter of September 25th, relating to "shortage of trained medical aid," has come to hand.

I am sending copies of your letter to the members of the C.M.A. Council with request for suggestions, and in due course will again write you.

In the meantime, may we ask you to send us such information as may be available from the files to which you have access, concerning the districts or communities in California where a shortage of medical personnel is now in evidence, and to what extent?

We all appreciate the increased work on physicians remaining in civilian practice, but they carry these increased burdens as part of their contribution in the existing emergencies.

How would you determine the fitness of medical graduates of foreign countries? (The California Board of Medical Examiners has shown that a considerable number of such foreign M. D.'s present false or misleading statements concerning former training.) . . .

If a grave emergency were to arise, and medical aid was rendered by unlicensed physicians, is it not more than possible that the State Board of Medical Examiners would take no notice or action concerning such violation of the law, looking upon the same as a pardonable technicality?

As stated in your letter, the present and future complications involved in temporary licensure are of a serious nature. It has taken almost a century of effort to bring standards of medical practice in California to their present status. It would be a real detriment to public health interests, if the existing standards were temporarily nullified, with future possibility of permanent influx of a large group of poorly trained physicians.

May I hope to hear from you in regard to the above?

Cordially yours,

PHILIP K. GILMAN, M. D.,
Chairman, C.M.A. Council.

Without going into details, it may be stated that other correspondence followed; and special study was given to the subject by the C.M.A. Committee on Public Policy and Legislation.

* * *

Proposals of the "Federation of State Licensing Boards."—Under date of December 10, 1942, a communication was received from Secretary Walter L. Bierring of the Federation of State Medical Boards, with which was enclosed "proposed legislation to authorize and provide for the temporary admission to practice in your state of physicians and dentists to protect the health of the civilian population during the war emergency period."

Also enclosed was a "statement of principles suggested as a means by which this relocation of physicians and dentists can be done."

The proposed law (Item A) and the statement of principles (Item B) appear elsewhere in this issue. (See page 36.)

In connection with the foregoing, space is also given to two other items bearing on the subject of modification of existing California statutes concerning medical practice. Of these, Item C (on page 37) enumerates some questions which would arise and be worthy of consideration when proposed amendments to the medical practice act are considered.

The comments having the caption Item D (on page 37) deal directly with the provisions outlined in the amendment (Item A), suggested by the Federation.

Because the subject of medical licensure standards is one in which every Doctor of Medicine who is licensed in California has an inherent interest, attention is here called to the above.

Component county societies and members who are interested are requested to communicate their views, on whether California's Medical Practice Act should be amended to provide for temporary licenses, to the Council of the California Medical Association, Doctor Philip K. Gilman, Chairman, 450 Suttter, San Francisco.

MEDICAL PUBLICATIONS FOR HOSPITAL STATIONS OF MILITARY CAMPS IN CALIFORNIA

Medical Libraries have given Generous Cooperation.—Notices containing requests for medical publications (journals and books) for distribution to hospital stations of military camps in California, have been given editorial and other comment in recent issues of CALIFORNIA AND WSTERN MEDICINE. The response thereto was not as large as had been expected, but journals, in considerable number, were received by the three medical libraries of California (Stanford, University of California, Los Angeles County Medical Association, and by the C.M.A. office). In addition, the three medical libraries made available from their shelves, a large number of duplicate volumes and these, with the journals, were shipped c/o Medical Officers in Command, to the hospital stations of many of the rather large number of Army and Air Force camps that are now located in California. Because the Navy stations are closely grouped and adjacent to the larger cities, where good library facilities are available, it was not deemed necessary to forward the publications to the hospital stations of that service.

Of course, the books and journals were not the latest editions or issues. However, since only sparse literature is available at some of the recently organized camps, it was felt that even such was better, than few or no medical publications.

From time to time, as material comes to hand, other shipments will go forward. The Postgraduate Committee has also voted to charge against its budget, the cost of sending CALIFORNIA AND WESTERN MEDICINE to all California camps, and if satisfactory arrangements can be made, to subscribe, in addition, to certain other publications to be sent to some of the hospital stations.

Military Colleagues are Appreciative.—Colleagues in the military service have expressed their appreciation of the effort to supply medical literature to their camps. Two copies of reply letters received are appended:

———— Training Detachment
Office of the Surgeon
————, California
January 3, 1943.

Subject: *Receipt of Medical Literature.*
To: *California Medical Association.*

1. This office is gratefully in receipt of the medical shipment, reference No. 17, dated December 22, 1942, sent by the C.M.A. Postgraduate Committee.

2. I cannot overemphasize our appreciation of the medical literature you have forwarded this office. The assistant surgeons and I, as well as some of the enlisted men have already begun poring over their contents. All I can say is that this gesture is very fine. . . .

Sincerely yours,
(Signed) ————,
Captain, Medical Corps,
Surgeon.

* * *

Station Hospital
————, California
January 4, 1943.

To: *California Medical Association.*
Gentlemen:

On behalf of the Medical Officers stationed at this hospital, I wish to extend to you our sincere appreciation of your effort to develop the medical libraries in the station hospitals. A packet of medical journals has just been received by us and our thanks are extended to you.

Please be assured that your efforts in our behalf are greatly appreciated.

Sincerely,
(Signed) ————,
Major, M.C.,
Surgeon.

SAVE YOUR HEALTH AND YOUR DOCTOR'S TIME

Excellent Leaflet of the Medical Society of the County of Westchester, New York.—Under the caption, "Save Your Health and Your Doctor's Time," physicians of White Plains and other communities in the County of Westchester, New York, have distributed to their patients a small and interesting leaflet, of size to fit into envelops with statements or other correspondence.

As the months go by, more and more articles are appearing in the lay press, in which the supposed "doctor shortage" is being emphasized—a topic that provides a good slogan for certain proponents of governmental medical care plans who are using it to carry on an educational propaganda in favor of their schemes and obsessions.

* * *

Implications in the Changing Practice.—By now, it is of course evident to all that, to transfer within the short space of a single year, more than 40,000 Doctors of Medicine from civilian practice into the ranks of the Armed Forces (with additional accretions to be made in 1943, until, as stated on another page, the total will swell to 52,400 physicians in military service), could not do otherwise than make for some dislocations in the type of service now available to civilians.

On the other hand, the fact that it has been possible to take so massive a number of physicians from civil practice, without extensive and widespread hardships in medical service being evident, is in itself one of the best refutations to those who, during the last decade, have been shouting themselves hoarse concerning "inadequate medical care."

For the information of C.M.A. members, it may be stated that reports are now being received from component county units of the California Medical Association concerning medical needs in their respective communities, the replies indicating, to date, that citizens of California are still receiving good medical care. More, concerning this, in a later issue.

True it is that, almost everywhere, members of the medical profession are working harder and longer than in former years, but the burden in most places has not been greater than the practicing physicians, themselves, have been willing to bear.

* * *

Merit of the Westchester Educational Leaflet.—Which brings us back to the educational leaflet that has been distributed by the physicians of Westchester County. Our New York colleagues have appreciated early that, under existing circumstances, medical service is a two-way proposition, requiring not only willingness on the part of the physicians to give good service, but coöperation on the part of citizens, to aid in the conservation of the health and time of their medical advisors.

The leaflet tells its story in simple and appealing manner. It is given space below, because of its suggestive value. It is possible that some of the component county societies in California may wish to print similar statements, and to furnish supplies to their members for distribution to patients. The Westchester leaflet follows:

(copy)

Save Your Health and Your Doctor's Time

Rationed Gas, Rationed Tires, Rationed Doctors!

A large proportion of Westchester's physicians have entered military service. Many more are preparing to go. Those left behind, with a few exceptions, are beyond military age, or have some physical disability which has disqualified them for active military duty. Yet these "home front" physicians are being required to carry a greatly increasing burden of work.

You and your family can help both to lighten this burden and to make sure that everyone will get the utmost benefit and safety from the limited medical service that will be available. Here's how:

1. Instead of asking the doctor to come to your home, go to his office when you can.

2. If a house visit is necessary, call the doctor before 8:30 in the morning or before 12:30 at noon, so he can plan his house calls efficiently. A morning temperature is usually followed by a higher one in the afternoon.

3. Don't neglect to inform your doctor of the early signs of sickness. A timely visit to your doctor may prevent serious illness, numerous house calls—even hospitalization.

4. Whenever possible, leave the message with the doctor's secretary. Don't call him personally to the phone unless it is really necessary.

5. Be patient with your doctor if you have to wait in his office, or if he does not respond at once to your call. Remember that he is caring for many more patients than formerly, and he has only twenty-four hours in his day.

You and your neighbors on the "home front" won't suffer from lack of adequate medical care, if we will all help the doctors carry their burden of extra service.

MEDICAL SOCIETY OF THE COUNTY OF WESTCHESTER

EDITORIAL COMMENT†

IMMUNOPOTENTIATING SEX-HORMONES

Clinicians have repeatedly reported a significant increase in natural or acquired antibody titer toward the end of pregnancy, suggesting a relationship between sex-hormones and specific immunity. Attempts to confirm this suggestion, however, have led to conflicting experimental evidence. Dingle,[1] for example, found that in rabbits administration of crystalline theelin produces no significant change in antibody titer; Weinstein,[2] in contrast, was able to demonstrate distinct increases in agglutinins and hemolysins following similar administration. A possible explanation of these discrepancies is suggested by Weinstein's studies of the effects of varying doses of sex-hormones on anthrax resistance, in mice, large doses and small doses often producing contrary results. The results also varied with different time intervals between hormone administration and the subsequent immunity test.

A detailed reëxamination of experimental evidence was therefore undertaken by von Haam[3] and his coworkers of the Department of Pathology, Ohio State University. 1200 carefully selected mice were tested in groups of 10 males or 10 females with an equal number of normal controls, a highly virulent strain of type I pneumococcus being selected as the test organism. Their routine test dose consisted of 0.2 cc. of an 18-hour broth culture injected subcutaneously. With this routine dose all of their control mice died within 26 and 36 hours after infection. Among the hormones tested were: (a) estrone, isolated from pregnant mare urine, (b) progesterone and (c) testosterone propionate prepared by the methods of Ruzicka and Kagi, and (d) stilbestrol, a synthetic estrogenic substance. Each hormone was dissolved in sesame oil (1 mg. per cc.), and was administered intraperitoneally, either as a single dose or as a divided dose given 3 times weekly over a period of from 2 to 8 weeks. Control animals were injected with similar doses of pure sesame oil. The effect of each hormone upon the course of experimental pneumococcus infection was determined by comparing the average life span and number of survivors to the infected in the control and sex-hormone treated groups.

In a typical test, a group of 10 male, and 10 female mice were given six injections each of varying doses of estrone over a period of 2 weeks. Each animal, together with a normal control, was then given the routine multilethal test dose of Type I pneumococci. All nontreated controls died between the 25th and 32nd hour. A distinct protective action was noted in mice given estrone doses ranging between 0.06 and 1.2 mg., nearly 33 per cent of the animals so treated surviving the infection. Death was delayed in the other 66 per cent to from 60 to 80 hours. Mice treated with smaller estrone doses showed less protection, while those given excessive doses (e.g., 2.4 mg.) showed deleterious effects, all hyperestronized animals dying within 23 hours. Similar though less pronounced effects were demonstrated with single doses (0.5 and 1.2 mg.) given 3 to 7 days before the test infection. If given only 1 day before infection the single dose was ineffective.

Parallel tests with progesterone and stilbestrol, showed no protective action. Testosterone propionate, however, protected both male and female mice to a moderate degree if given at a dose level of 0.001 to 0.1 mg. With higher doses, however, the protective effect was increased with male mice, but decreased resistance was noted with females.

In order to determine the probable mechanism of this favorable effect of sex-hormones a study was made of the effects of estrone on the rate and amount of specific antibody production in rabbits, formalinized type I pneumococci being used as the immunizing agent. One mg. estrone in sesame oil was administered by intraabdominal injections three times weekly. The injections were begun 2 weeks before administration of the vaccine and continued throughout the entire immunization period. The vaccine was given according to the "four week complete system" of Goodman,[4] each animal receiving 4 series of 4 daily injections with small but increasing doses of the vaccine with a 2-day rest period between series. Blood was usually drawn 10 days after the last vaccine dose and tested for agglutinin and mouse protective titers. In some cases blood samples were drawn at 5-day intervals through the immunization and post-immunization period.

In a typical test 12 carefully selected female rabbits were divided into two groups. One group of six rabbits was given a 2 weeks' preliminary estrone treatment. Both groups were then sub-

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

jected to the routine 4-week antipneumococcus immunization. Ten days after the final vaccine dose the control group yielded serums with an average specific agglutinin titer of 1:21. The average titer for the estrone-treated group was 1:173. This suggests a 6-fold increase in specific antibody production as a result of estrone therapy. Simultaneous tests showed that 0.5 cc. of the serum of the estrone-treated group protected mice against 40,000 M.L.D. of highly virulent type I pneumococci. The control group protested only against 3000 M.L.D., suggesting a 13-fold increase in specific protective titer as a result of sex-hormone therapy.

In other groups of rabbits the relative speed of antibody production was determined by periodic titrations during the process of immunization. In the control group circulating antibodies were not demonstrable till 20 days after the initial vaccine does. In the estrone-treated group antibodies were demonstrable as early as the 10th day. The control titer reached its maximum on the 30th day, and then fell to zero by the 50th day. In the estrone-treated group antibodies persisted well beyond the 70th day.

Similar results were obtained with castrated male and female rabbits. The general conclusion drawn from these experiments is that the administration of estrone before and during the process of immunization produces a remarkable increase in both specific agglutinin and specific protective antibody titer in both castrated and noncastrated rabbits of both sexes. Antibody production starts much earlier as a result of estrone-therapy, reaches a higher titer, and disappears more slowly than in nontreated controls.

If adequately confirmed, this immunopotentiating action of estrone may have numerous practical applications in the commercial production of antiserums and in numerous fields of clinical medicine. Moreover, the finding is of basic biological interest, since it suggests a new teleological rôle for the sex-hormones, a purposeful augmentation of the humoral defenses, furnishing additional environmental protection for the growing embryo. The physiological method by means of which estrone increases the immunopotential of the reticuloendothelial cells, however, has not yet been determined.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCES

1. Dingle, J. H., Meyer, R. K., and Gustus, E. L.: Jour. Immunol., 30, 139, 1936.
2. Weinstein, L.: Yale Jour. Biol. and Med., 11, 369, 1939.
3. von Haam, E., and Rosenfeld, I.: Jour. Immunol., 43, 109, Jour. Infect. Dis., 70, 243, 1942.
4. Goodman, K., Horsfall, F. L., Jr., and Dubos, R. J.: Jour. Immunol., 33, 279, 1937.

The point is, not how long you live, but how nobly you live.

—Seneca, *Epistulae ad Lucilium*. Epis. ci, sec. 15.

VACUUM STERILIZER

A promising new method of sterilizing porous materials by vacuum exposure to germicidal gases is currently suggested by Salle[1] and his coworkers, of the Department of Bacteriology, University of California, Los Angeles. Experience has shown that the commoner bacterial contaminants (e. g., S. aureus, E. coli, and B. subtilis) are usually not killed by 2 hours' exposure to formaldehyde vapor under ordinary atmospheric pressure. The California bacteriologists found that the same microörganisms are killed in from 5 to 10 minutes if exposure is made under greatly reduced atmospheric pressure. To effect this sterilization artificially contaminated glass slides or dental cotton rolls were placed in a vacuum chamber which was evacuated to 29 mercury inches or 1 pound residual atmospheric pressure. Formaldehyde gas was then generated in the vacuum chamber in sufficient amounts to produce a one-inch drop in the vacuum. Of the eight bacterial species used in these tests, six were completely sterilized by the end of 5 minutes. Even their most resistent bacterium (B. subtilis) succumbed in 10 minutes. The authors believe that this increased efficiency of formalin vapor is due solely to its increased penetration into the contaminated materials. They conclude that "the method is efficient, cheap, easily performed and indispensable for the sterilization of objects likely to be injured by the application of dry or moist heat." Thus far acid-fast bacteria and pathogenic viruses have not been tested by the partial vacuum method.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

REFERENCE

1. Salle, A. J., and Korzenovsky, M.: Proc. Soc. Exp. Biol. and Med., *50*, 12 (May), 1942.

"Science and learning are definitely internationalized, and whether we wish it or not an indelible pattern of unity has been woven into the society of mankind. An American soldier wounded on a battlefield in the Far East owes his life to the Japanese scientist, Kitasato, who isolated the bacillus of tetanus. A Russian soldier saved by a blood transfusion is indebted to Landsteiner, an Austrian. A German soldier is shielded from typhoid fever with the help of a Russian, Metchnikoff. A Dutch marine in the East Indies is protected from malaria because of the experiments of an Italian, Grassi; while a British aviator in North Africa escapes death from surgical infection because a Frenchman, Pasteur, and a German, Koch, elaborated a new technique. In peace and in war we are all of us the beneficiaries of contributions to knowledge made by every Nation in the world."—The 1941 Report of the Rockefeller Foundation.

The rural dweller in the United States has, on the average, four or five years longer life than the urban resident. Among white males dwelling in rural areas the average length of life is 62.09 years, while for urban residents, it is 56.73 years. The corresponding figures for white females are 65.09 years and 61.05 years. These figures are based on the calendar year 1930.—Louis L. Dublin, Ph.D.

ORIGINAL ARTICLES

Scientific and General

THE CARE AND MANAGEMENT OF THE VOLUNTEER BLOOD DONOR*

JOHN R. UPTON, M. D.
San Francisco

BLOOD BANK staffs throughout the country have a triple responsibility; to the recipient, to the donor, and to their own Blood Bank. I shall touch briefly on a few matters pertaining to the donor; in the last analysis, his is the essential contribution in the bottle.

SOURCE MATERIAL

The following observations were made on 11,586 volunteer blood donors: 6,586 of these passed through the doors of our nonprofit Irwin Memorial Blood Bank of the San Francisco County Medical Society from June, 1941 to May 19, 1942.

A first-time blood donor is always frightened, no matter how he tries to camouflage his feelings. This is not to be wondered at. So long as he can remember, the sight of his own blood symbolizes to him, the word pain, be it a cut finger, a lacerated knee or a burned hand. He comes in fighting himself and the primitive urge to survive. Blood to the average layman is still a mystery fluid; he knows that if he has enough he lives, if he loses too much, he dies. The wonder is that so many people present themselves for this, our modern humanitarian service. Life and Death, Fear and Pain: these basic emotions are deeply ingrained in men, and they cannot be erased by a glib catchphrase or a cleverly turned slogan. An impelling force must urge the hesitant man into being a determined blood donor. An awakened patriotism for his country, a deep religious fervor, the stubborn love of a man for his ailing child—tap these eternal emotional springs and the donor lines will never slacken. In the United States, as yet, we have suffered no Pearl Harbor, no Coventry, no Rotterdam; if we had, we would not have to ask for donors.

We cannot pick out any stratum of our complex society as being the most desirous of helping. Clerks, society girls, toilers, bankers, etc., all donate their liquid quota, but that great section of society lying between the haves and the have-nots forms the reservoir from which most of our donations are drawn.

THE GROUP INSTINCT

The herd instinct is graphically portrayed while recruiting volunteer donors. Our Blood Bank speakers would rather talk to groups than to individuals; for the camaraderie between members of the group is infectious, the humorous raillery compelling, and the wish to be "one of the boys" most eloquent to our end result of securing donors. Our speakers' time is likewise valuable and their results are multiplied. Influence groups, arrange appointments so that they may come together as a body. The inherent desire of human beings to be well thought of in their own set is strong; even timid folk will volunteer if they can go with "the gang." Our experience has been that, of the number who sign up, 50 to 60 per cent never present themselves at the Blood Bank.

INITIAL APPROACH TO DONOR

I particularly stress the mental and physical capabilities of the first person to greet the prospective donor. In our Institution, the part falls to the assistant Secretary and Receptionist. Courtesy, tactfulness and charm on the part of the first staff member greeting the hesitant donor will largely determine the difference between a 200 c.c. worthless draw, and a full 500 c.c. take. Let no one belittle the Receptionist; she is one of our key figures. This fact is also true of the Telephonist; her voice spells the difference between no blood at all, or a willing donor. Too many prospective applicants have been turned away by the "Indifferent Telephonist." We tried several girls before finally securing one who could dexterously and amicably settle the many ticklish problems that arise before and after the liquid donation.

Volunteer donors will smilingly take bare walls, bare floors, and bare cots if need be, but they will *not* take the cold impersonal guinea pig method adopted by some Blood Bank staffs. Large-scale blood withdrawals, day after day, required expert teamwork on the part of the staff; donors literally are placed on a modern production line. A skilled and careful craftsman will lovingly care for the intricate but inanimate motor car as it passes under his hands, and so must each human machine be quietly, cheerfully and considerately handled. All too frequently the cryptic notation on the donor's card "small veins" is, in reality, a "cover-up" for some imperfection in the assembly line, be that defect a snub from a smug hostess, an inadvertent remark made by a tired nurse, or the curt impersonal attitude of the doctor. The Staff must show the keen interest that they should feel for these, their patients; for, mark it well, they are their patients. I would caution against pushing the Staff too hard, they can "take it" for several days, but after that something happens—that something is contamination. Dry taps or small quantity takes are expensive in equipment and personnel time; they must be reduced to a minimum.

ROUTINE PROCEDURES

Such essentials as the short medical history, pulse rate, blood pressure, temperature and an accurate hemoglobin determination are necessary Blood Bank procedures, and must be routinely

* From the Irwin Memorial Blood Bank of the San Francisco County Medical Society.
Read before the American Human Serum Association, Atlantic City, N. J., June 8, 1942.

performed and recorded on the donor's card. Standards promulgated by the National Research Council are quite adequate and, if conscientiously followed, will protect the recipient, the donor and the Blood Bank. Physical deviations of donors from these accepted standards must be accepted or rejected by the doctor in charge, and not by a lesser member of the Staff. It requires rare tact to refuse some people; a disgruntled and perhaps suspicious person can cause a great furore in the community if he is allowed to leave the Blood Bank with a supposed grudge.

FAINTING PROBLEM

A physically small person does not worry us the way he used to. Naturally, we prefer a donor whose weight is over 120 lbs., but a short, stocky person withstands the slight ordeal of blood-letting easily. Beware of tall, thin people. Most of our faintings occur in this group. After a veni-puncture, more care is shown them, such as a longer period of rest, and they are advised to take it easily the rest of the day. The reason for these somewhat alarming reactions in tall, thin people is a simple problem of bio-physics. We prefer the shorter, stockier donor and, preferably one who falls into the 36-to-50 year age group. Younger people faint more frequently than their elders. It almost seems that in sending the youth of our land to fight, Providence permits the 36 to 50 year old group to stay behind in order to provide them with blood; certainly added years gives not only mental stability, but more vasomotor stability.

PRELIMINARY INTAKE OF FLUID AND FOOD

The pertinent question of food and fluid for blood donors deserves more thought. A. C. Ivy and associates recently reported their experimental work on dogs, and found that there were fewer reactions in their animals when both donor and recipient dog had fasted. Their careful analysis shows that, fast one and not the other in the recipient-donor set up, and the percentage of reactions rises—a new and provocative idea, and one to be further clarified in human beings. Of course, some patients requiring transfusions are inadvertently fasting because of their diseased state or debilitated condition. We only ask our donors not to eat *fats* for four hours before presenting themselves. We like our donors to take a little fatless fluid and food just prior to their reporting at the Blood Bank. It is quite true that blood from a fasting donor yields clearer plasma or serum than that from one who has partaken of even fat-free fluids and food. On the opposite side of the ledger is the fact that the longer the donors fast, the more frequent are the number of faints. Immediate or delayed faints will not help the reputation af a Blood Bank. We must all strive to lessen their incidence. Our Staff members greatly dislike to start a busy day with a faint. They say this stigma seems to unconsciously touch each succeeding donor and they notice a tautness, a certain uneasiness in the donors which requires extra care to allay. I sense that the Staff also is more brittle in temper after some untoward incident, and this straining quality of theirs may be transmitted to the donor.

DELAYED REACTIONS

Our biggest bugbear is the delayed reaction; we define the term as a reaction which takes place after the donor has left the Institution. At least half an hour elapses between entry and exit of the donor with at least ten minutes of this period being given over to rest in the prone position. Our mean bleeding time for both sexes is five minutes. We have no statistics on these delayed reactions as yet, but our various City Emergency Centers are coöperating fully in reporting them when they occur. Such Centers likewise have been requested to minimize the incident to the affected donor. This last phase is highly important, for here is an opportunity for malpractice suits to be launched by ill-advised people, or by Axis sympathizers.

CAUTION CONCERNING HARD CANDY

We would caution on the giving of hard candy prior to or during a drawing. This in substance is sound, as quick sugar energy is beneficial. We were experimenting with various rapidly absorbed energy foods and fluids that were given to our donors just prior to the veni-puncture when an incident occurred. The near tragedy of this donor stopped the hard candy practice in our Blood Bank. The donor fainted, the candy became lodged in his trachea and it was only the quick action of our Staff Doctor in extricating the impediment that prevented a possible catastrophe.

COMMENT

We try to maintain our large donor room at a temperature of 68-70°F. More important than heat, from the donors' standpoint, is that of air stagnation. Air should circulate freely through the room. This is an easy matter when the cots are not confined in cubicles; but when the individual or double cubicle system is utilized, greater care should be made for adequate air movement. Cigarette smoke may benefit the few after their donation, but it upsets the majority. We allow no smoking in the donor room.

In our first few months of operation, the percentage of female donors to male donors was three to one. At the present time, the sexes are about equal in number; women like morning hours, between 9 and 11, while males prefer the hours between 4 and 7 p. m. Work hours have naturally been the main factor in causing the male influx late in the afternoon. We expected these end-of-the-day workers to show some fatigue changes; this, however, has not been the case. Perhaps the forty-hour week is responsible!

Female finger nails early attracted our attention, and an interesting fact was noted. The prevalent fashion for women to allow their finger

nails to grow to prodigious lengths makes it physically impossible for such women to clench their fingers into the palm of their hand when giving blood. Muscular action is therefore necessarily slight, and the rate of blood flow is slackened; when such a woman tries to clench her fist, sharp nails press into the flesh of her hand—so, she does not clench. A simple and very efficient expedient was found in the form of a padded hard rubber dog-bone, such as is given to puppies to play with and to bite. A hard rubber dumb-bell or a short segment of garden hose will also serve the purpose. We place one of these rubber "bones" in the hand of the female donor and say: "Chew on that!" The result is an increased flow of blood and a subsequent shortening of the bleeding time. Most donors like to have something to squeeze while donating their blood; their fingers do not tingle, and as this symptom is the only effect noted, its abolishment is worth while.

CAUTIONS

If there is the slightest possibility of an hematoma developing at the veni-puncture site, we are careful to notify the donor as to its slight significance, and the simple rules for treatment of the condition. I am sure all of us have received midnight telephone calls from occasional worried persons when they discovered the rather fearsome blood staining of the subcutaneous anti-cubital area tissue. Such anxious folk are asked to report to the Blood Bank for an examination and treatment. If this is difficult for them, one of our Staff makes a home visit. Several irate and potential trouble-makers have been mollified by this courtesy—it pays.

TECHNIQUE

The doctors or supervised nurses who perform the actual blood letting must scrupulously follow this advised technique in terminating the veni-puncture. If the bottle used employs the closed-system gravity method, the sphygmometer or tourniquet pressure must not be released until the tube leading to the bottle is clamped. This necessary precaution prevents any incident occurring from the possibility of a positive pressure being created in the drawing bottle. If the arm-band pressure is released before the bottle clamp is shut, the donor may take in considerable air via the punctured vein. This is especially true if the donor suddenly faints, for then a reversal from the normal to a greatly lowered blood pressure would initiate the process which might terminate in a massive air embolism.

If negative pressure appliances are used on the air filter inlet-outlet system of the drawing bottle, especial watchfulness is necessary. Several instances have been brought to my attention by other drawing centers where the attendant unknowingly built up a positive pressure in the bottle and thus considerable air was forced into the punctured venous system. I am almost convinced that the negative-positive pressure bulbs and other similar appliances are dangerous; certainly, if they are used, they should be tested each time they are applied to the bottle.

SABOTAGE RUMORS

I was considerably alarmed during the first few weeks of this war by vicious verbal sabotage. A new rumor a day was about the average, and most rumors were definitely of a damaging nature. Immediate and firm measures were taken to locate their source. This, however, was not always possible, and so the radio and newspapers were utilized to mitigate the effectiveness of this deliberate falsehood campaign. The unfortunate thing was that many rumors were started by misinformed folk. Damage, however, was quite as effective to our blood-procurement cause as that resulting from the subversive action of Axis sympathizers in any defense industry. Blood and its use appears to hypnotize the average lay person, and they listen with avidity to tales pertinent to blood letting. This fact has been well noted by certain subversive groups and we are continually on guard to combat false stories. A policy of public enlightenment on Blood Banks, and their rôle in the war effort, is advisable. The recent trend to publish articles on Blood Banks in our national magazines is laudatory; but after reading a few, I would suggest such print be passed on and checked by a competent Blood Bank doctor. Several articles were "sensational" and were far from being accurate.

NO DISPLAY OF BOTTLES

Most donors ask to see their own bottle of blood after it has been drawn. If they insist, we show them the bottle when only a few c.c.'s have been drawn; for otherwise, when they see the full pint of blood, the most common phrase has been: "Did all that come from me?" The rapid change of facial colour, the lowering of the blood pressure and other clinical manifestations of syncope showed the psychic shock they had sustained, so we try not to show the donors their blood any more. Likewise we shield the bottle on the opposite couch so it cannot be seen. Our nurses and nurses' aides are expert in talking about usual everyday occurrences, and a deliberate attempt is made during the drawing to keep the donors' mind off the slight operation they are undergoing. However, the tenacity with which the majority of donors will attempt to pull the conversation back to the topic of blood again, bespeaks the tremendous interest in this subject. We subtly discourage such references, as primarily we are anxious to obtain a full 500 c.c. take without the donor suffering any inconvenience. Allow unrestrained comments to be made about blood in a donors' room, and it is actually possible to graph the decreased take of blood.

IN CONCLUSION

In short conclusion.—War's urgent necessity, and the skill of our scientists, have made us

guardians of an inexhaustible supply of liquid wealth. That being so, we must turn our thoughts and some energies to the future medical welfare of our Nation. The present volunteer blood donor must not become a forgotten man when this war's turmoil is over. His potential service is too valuable to the Nation's economy. Democracy's peace-time battlefields are the highways, the industrial plants; the daily blood requirements for their maimed and injured are enormous.

Our medical research workers are striving desperately to fashion a substitute for human blood plasma and ultimately they will succeed. To us has been given a therapeutic weapon of great value; the medical profession must safeguard that weapon from abuse and from dissipation.

384 Post Street.

BRONCHOSCOPY: ITS RÔLE IN THE TREATMENT OF ASTHMA

JOHN L. GOMPERTZ, M. D.
Oakland

BRONCHOSCOPY has been one of the many modalities used and abused in the treatment of asthma for many years. In some cases its use is a spectacular success, while with other patients, it is a dismal failure. In examining the causes for both of these results, certain facts stand out which will be emphasized in this paper.

Clerf[1] has pointed out that a wheeze is simply an audible manifestation of a narrowing of the airway, and should be investigated as a symptom of obstruction. A careful history, with a complete physical examination and judicious use of the x-ray, will eliminate many cases that are not true bronchial asthma and, therefore, may be disregarded here.

Bronchial asthma should not be considered as a separate disease entity, but rather as a complex of conditions culminating in dyspnea. The underlying conditions are allergy and infection, but it is the relief of the severe dyspnea, as well as the prevention of its recurrence, plus facilitating pulmonary drainage, that concerns the bronchoscopist.

ETIOLOGY

The real cause of the severe dyspnea that occurs in asthma is obstruction of the airway somewhere along its course. This obstruction is due to one or more pathologic conditions of the bronchial tree and its various component parts. Allergy and infection play leading rôles in producing those conditions.

Miller[2] and his associates have pointed out four causes of bronchial obstruction in allergic patients:

1. Spasm of the bronchial musculature, producing bronchial constriction.

2. Thickening of the walls of the bronchi and bronchioles from edema, hyperplasia, hypertrophy and cellular infiltration.

3. Secretion of a very thick and tenacious mucous in the bronchi.

4. Paradoxic collapse of the bronchi during cough and expiration.

A fifth cause may well be the localized, stricture-like narrowing of a bronchus, often found in asthmatics and described by Prickman and Moersch[3]. Most of the people in this last group give a history of pneumonia.

PATHOLOGY

Huber and Koessler[4] have described the following changes in the bronchial tree:

1. Thickening of the walls of the smaller bronchi involving all coats.

2. Spasm of the muscular coat.

3. The mucosal glands are usually swollen and very active. In cases without sputum the glands are found to be atrophic.

4. Infiltration of the bronchial wall by lymphocytes and eosinophyles. Bronchial smears will often show a high eosinophyle count.

5. Curschmann's Spirals, which are simply an arrangement of mucous threads within the casts of the bronchi, sometimes containing Charcot-Leyden crystals.

Moore[5] quotes an excellent description, by G. R. Moffitt, of the histopathologic changes that occur in the bronchial musoca. Moffitt concludes that one or more of the following changes occur in the ciliated columnar epithelium of the bronchi in asthmatics:

1. Loss of the ciliary motion which produces the current.

2. Complete loss of all ciliary motion (he describes two types of motion).

3. Actual loss of cilia.

4. Fatty degeneration.

The net result of the above changes is that the patient has great difficulty in draining the bronchial tree by coughing.

BRONCHOSCOPIC FINDINGS

Among Clerf's[1] cases, there were two noteworthy bronchoscopic findings in true asthma.

The first was collapse of the walls of the trachea and bronchi during cough and forced expiration. This condition varies greatly in degree among different patients whom we have observed, and its cause has been a source of speculation. However, it is not bronchial spasm.

The second finding was the presence of abnormal secretions. These are sometimes so thick that they will not flow down the side of a glass tube. The best results in the treatment of asthmatics by bronchoscopy are secured in patients who have chronic tracheo-Bronchitis with considerable secretion, which may be either mucoid or purulent in character. This is what Weille[6] calls Intrinsic (Exudative) Asthma.

There are other conditions with which asthma may have a causal relationship, and in the treatment of which bronchoscopy may play an important part.

In 1930, Wilmer, Cobe and Lee[7] noted a definite relation between allergy and postoperative atelectasis. In their series of cases of postoperative atelectasis a high percentage gave a definite history of allergy.

Further confirming this observation, many cases of pulmonary atelectasis, and some cases of massive collapse of the lung in asthmatic children, have been reported by Tucker,[8] Peshkin and Fineman,[9] Kahn,[10] Maxwell[11] and others. In all of these cases, either asthma or some other definite allergic state, was considered to be the underlying cause of the condition, and in the great majority of cases relief or cure was obtained by bronchoscopy.

Bronchial asthma, with its obstructive phenomena, has been suggested as an antecedent of bronchiectasis, and this is much more likely in those asthmatics having definite bronchial stricture.

TREATMENT

Bronchoscopy is of benefit to those asthmatics who have either bronchial secretion in large amount with diseased epithelium that hinders drainage, or where the secretion is so thick that cilia, coughing or posture have no effect upon it. Direct aspiration is a boon to these patients.

Lukens[12] has pointed out that by bronchoscopy, specimens of bronchial secretion may be obtained that are free of oral contamination. Some patients are greatly benefited by autogenous vaccine made from such material, when they receive no benefit from vaccine made from smears of their nose and throat.

The patients showing collapse of the walls of the trachea and bronchi, are benefited by bronchoscopic drainage many times, even when the secretions are not abundant. This procedure seems to lessen the inflammation and hence the collapse of the walls.

The cases that are not benefited by bronchoscopy are those of mistaken diagnosis or those whose wheezing is due to some other disease condition. There is a large class of true asthmatics also who are not benefited by this treatment. They are the people who don't have much secretion, whose attacks are precipitated by known allergens, and are prevented or relieved by appropriate desensitization and medication. Bronchoscopy and the patients are both abused by its use upon them.

CONCLUSIONS

Bronchoscopy is of definite benefit to the asthmatic patient whose bronchial tree needs draining and who is unable to accomplish this unaided. Direct aspiration to remove excessive or very thick bronchial secretions will not only relieve the dyspnea, but will aid in controlling bronchial infection if present. We have seen asthmatic patients made quite comfortable, and kept so by periodic bronchoscopic aspiration.

To achieve good results, the infection or allergen, that causes the bronchial irritation and mucosal response, must be eliminated. Appropriate allergy treatment must be combined with bronchoscopy.

Those patients who have very little secretion, or whose bouts of dyspnea are promptly relieved by an injection or other treatment, are very seldom helped by bronchoscopy.

Bronchoscopy is definitely an aid in clearing up cases of postoperative atelectasis.

SUMMARY

1. The etiology and pathology of bronchial asthma are reviewed.

2. The bronchoscopic findings in bronchial asthma are noted.

3. The association between allergic states and pulmonary atelectasis and massive collapse is stressed.

4. The type of asthmatic patient benefited by bronchoscopy is described.

5. Certain types of asthmatics who were not benefited by bronchoscopy are enumerated.†

426 Seventeenth Street

LEG LENGTHENING OPERATION: ITS PRESENT STATUS*

ALVIA BROCKWAY, M. D.
Los Angeles

SHORT legs are common in orthopedic clinics. Injuries of epiphyses in legs still growing, diseases such as tuberculosis and osteomyelitis involving the growth plates, poliomyelitis, fractures that have healed with shortening, congenital short leg, untreated congenital dislocation of the hip, are some of the causes of short legs. Over the past 12-year period we have done at least 150 operations to equalize leg lengths, 109 of which were the leg lengthening operation. This means an average of about one patient each month.

There are five ways in which difference in leg length may be approximated. The two less important methods will be discussed first.

AMPUTATION WITH PROSTHESIS

This method is seldom used, mainly because the surgeon too often fails to see the possibilities. Under certain conditions it is ideal, in fact the only method to consider. Consider the young

† For references to article on Bronchoscopy, see page 20.

* Read before the Section on Industrial Medicine and Surgery, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.
From the Clinics of the Orthopedic Hospital, Los Angeles.

adult poliomyelitis patient with severe paralysis in one leg with marked shortening, but who fortunately has still fairly strong abductor and extensor muscles of the hip, at least adequate to control an artificial leg. Instead of a lifetime heavy brace with a high shoe raise, a weak useless leg, a limb of unpleasing cosmetic appearance, this patient should have an amputation at the knee, with an end-bearing patella stump. The legs are now the same size, the same length, better appearance and better function. This patient will be everlastingly grateful to you for your insistence on amputation.

Consider, also, the patient with a congenital short leg of 4 inches or so, with a small, deformed club foot, possibly with limited painful function due to surgery that turned out poorly. This patient is an ideal candidate for amputation in front of the os calcis, saving the heel for end-weight bearing or amputation at the conventional level at the junction of the middle and upper thirds of the leg.

EPIPHYSEAL STIMULATION

This operation has had support from individual surgeons from time to time, but on the whole the results are inconsistent and disappointing. In this operation a number of drill holes are made across the tibia or femur near the epiphyses at the knee or hip, or both, and some prefer to stuff some of the holes with heavy catgut to act as an irritant in the hope that increasd vascularity will hasten growth in length. The rationale of the operation is based on the fact that it has been repeatedly observed that fractures, especially of the femur in young children, removal of bone grafts from the tibia, and chronic osteomyelitis near the epiphyses, may cause that leg to grow from ½ inch to 1½ inches too long.

It is ideally used in the young child with a congenital short leg in which observation shows increasing discrepancy in leg lengths. Unfortunately, we never know just how much good we have accomplished, because the best we can hope is that the difference will not increase. Anything we may gain is pure profit, and will make future leg-equalization surgery less radical. Some surgeons report a gain of ¾ to 1¼ increase in length.

EPIPHYSEAL ARREST

This operation is upon much sounder foundation than epiphyseal stimulation. From our studies of growth, we know fairly accurately how much each epiphysis of the femur and tibia and fibula will contribute to the growth of a leg at any given age. Conversely, then, we know that if a certain epiphyseal line is destroyed at a given age, then the growth in length will be retarded that much.

The operation is safe and the convalescence is short, but it has certain limitations and objections. In the first place the surgery must be done while the leg is still growing and the expected growth from the epiphysis or epiphyses must be equal to the shortness in the opposite leg. Once that age is passed surgery cannot completely compensate for the difference in length when growth is over.

Secondly, our figures on expected growth from various epiphyses represent an average of a number of studied cases. When an individual patient comes to us we are forced to use a general rule for his specific case which may not always be accurate. Computation is made still more difficult if there has been a partial epiphyseal closure in either leg due to injury or disease.

Thirdly, the result of the operation is not entirely known until after the end of growth and, furthermore, we do not have enough end-result studies to actually know the whole truth; and for this reason we do not know enough about possible deformities resulting from imperfect surgical closure of the epiphyses.

Lastly, the height at maturity has been shortened.

In spite of all these possible objections, we do now know that many good results are obtained and the operation has been gaining in favor.

LEG SHORTENING

This is a very positive way of equalizing leg lengths. It is positive in that the preplanned amount of bone can be removed and there is no waiting until the end of growth to see how much has been accomplished. The operation is no simpler than leg lengthening but is somewhat safer; there are fewer complications, and the convalescence is shorter.

It has the disadvantage of making the patient shorter instead of taller, a fact which is more important if the patient is of short stature. Sometimes the patient, as well as the surgeon, are hesitant to operate on the good leg, especially if the short leg is of very poor function. They may not wish to risk the possibility of two poor legs.

Leg shortening should be done in the femur, preferably in the extreme upper end while leg lengthening should be done below the knee.

LEG LENGTHENING

To Abbott of San Francisco must go the credit for the impetus in the interest of leg lengthening in this country. As a result of his early work we started this operation and have been doing them steadily since. At present we are doing more leg shortening and epiphyseal arrests, but we have done 109 leg lengthenings in the past twelve years, and consider it still a sound safe operation in the hands of the experienced.

It has the advantage that it increases the height and restores the patient to the stature that nature intended. It places the operation on the limb of poorer function. The disadvantages of the operation are the complications that may result.

Generally speaking, a poliomyelitis leg may be lengthened from 1¾ to 2¼ inches with comparative safety and the unparalyzed leg from 1¼

to 1¾ inches. It is possible to obtain more length but if we are content with the above limitations, there will be fewer complications to report.

In the average case, the lengthening process proceeded at the rate of 1½ mm. per day, the lengthening apparatus was removed in 2½ months, the plaster cast removed in 6 months and full weight bearing begun at 9 months.

Success of the surgery depends to considerable extent on everlasting vigilance during the lengthening process. Due to the heavy calf muscles there is marked tendency to anterior bowing of the tibia. This failure to maintain good alignment of the fragments bring about most of the grief associated with the operation.

Bowing means separation of fragments, which means delayed union. Bowing also will cause the fragment ends to project through the skin, or at least to cause pressure necrosis of the skin over the shin and later sloughing of soft tissue and exposure of the bone. This accounts for the infections that sometimes develop and the secondary surgery that is necessary to clear up the bone infection.

Too much lengthening will cause limitation of motion in the ankle due to the long-continued pressure force on the ankle. In two instances, the fibula pulled up from the ankle to give a valgus foot deformity, and in a few the head of the fibula pulled down from its mooring at the knee but this did not cause any instability of the joint or decrease in function or pain.

Experience has taught us that lengthening of the femur is not a safe procedure, and we now do all our lengthening below the knee.

Most surgeons feel that leg lengthening should be done after the growth period is over, because we then know the amount of permanent shortening. There are some exceptions to this rule, however. It occurs many times that the shortening is already as great as it will be safe to lengthen the leg. Therefore, there is no point to wait longer because the younger patients grow new bone faster and better tolerate the stretching of soft tissue incident to the operation. Also, it is better to do the other reconstruction surgery in the poliomyelitis leg after the leg lengthening, if it is possible to so arrange it. Also the difference in leg lengths is sometimes of such a degree that it will be necessary to combine the leg lengthening with either a leg shortening or an epiphyseal arrest at a later date.

Congenital short legs have increasing discrepancy in length for a time, but later level off and the difference then usually remains the same. Such legs may be lengthened before the end of the growth period. Six legs were so lengthened, and there was no further discrepancy when growth was completed.

If the shortness is due to epiphyseal destruction, then obviously the short leg will not keep up with the normal leg when the operation is done before growth is over. Also, we have learned that poliomyelitis legs with much paralysis, and lengthened when young, will not keep up with the good leg after surgery.

The complications that may occur are not so serious in the partially-paralyzed leg, because these patients usually require other reconstruction surgery on the leg, and this, together with the added deformity incident to the surgery of the leg lengthening operation, may be combined at a later date. About 60 per cent of the legs that have been lengthened were due to poliomyelitis.

In this type of leg with considerable weakness at the hip or knee, the legs should not be made the same length, but should remain ½ to ¾ inches shorter even after the lengthening operation. If the weakness is chiefly in the leg and foot, the legs may then be made the same length. Taking into consideration that our first cases of leg lengthening were done without precedence to guide us, the results after a 12-year trial have been more than satisfactory.

Some 65 per cent were classified as extremely good, 22 per cent good and 13 per cent poor. Now that we know the dangers and potential dangers, the poor results will be decreased although it should be understood that the operation will never be without some hazard.

SUMMARY

1. Five ways of making a short leg longer are described. Each has its advantages and disadvantages.

2. The results of 109 cases of leg lengthening over a 12-year period are described. The operation is practical and sound when done below the knee.

3. Leg shortenings above the knee and epiphyseal arrest operations are now more common than leg lengthening. The complications are less and the convalescence shorter. The chief disadvantages of both are that the height is decreased and the surgery is done on the good rather than the poor leg.

2417 South Hope Street.

CLASSIFICATION OF MYELITIS*

WALTER F. SCHALLER, M. D.
San Francisco

IN its defined meaning the termination "itis" signifies inflammation. Usage has applied this designation, however, to a variety of conditions, some doubtfully inflammatory in nature as, for example, certain types of arthritis. The same may be said of "neuritis," a much-misused term, and also of myelitis, with the classification of which we are concerned in this paper. Indeed, myelitis always has been a vague and ill-defined term in neurologic nomenclature. This has been due to our lack of knowledge, not solely of etiologic fac-

* Read before the Section on Neuropsychiatry, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

tors, but also of histopathologic identification of the process concerned in diseased nervous tissues. This problem was discussed following a paper by Ferraro[1] on demyelination in the nervous system. To Globus inflammation meant pathology due to an intrinsic living agent; degeneration, primary dissolution of tissue. Ferraro and Putnam called attention to the extreme difficulty, and often impossibility, of distinguishing between inflammatory and degenerative process by aid of the microscope, or, indeed, of making a definite microscopic diagnosis of widely-different disease processes. For example, Putnam doubted that solely by tissue examination one might identify post-vaccinal encephalitis, brain trauma, or nitrous-oxide poisoning. This difficulty is well brought out in the controversy which has arisen concerning the nature of multiple sclerosis. At first considered to be inflammatory in nature, the present tendency is to regard the condition as either toxic or degenerative. To quote the noted neuropathologist, Spielmeyer: "I myself have considered multiple sclerosis to be of inflammatory origin for many years; but if somebody should say that the infiltration is only a symptomatic inflammation as a result of destruction and reparation, I should not be able to contradict him." In this connection, Spielmeyer was referring to the perivascular infiltrates, and particularly to the kind of cells they contained. It has been alleged, by Lhermitte[2] for example, that a perivascular exudate in a degenerative process never contains plasma cells; however, large numbers of these cells have been noted in mushroom poisoning. The presence of plasma cells and lymphocytes in perivascular accumulations containing scavenger cells in predominance, has been called symptomatic inflammation, i. e., secondary to the primary degenerative process.

In the United States Hassin especially has protested that the presence of the foregoing type of cells necessarily means primary inflammation. Ferraro includes eighteen differently-named diseases under the heading of patchy or diffuse sclerosis. The lack of a constant clinical picture, and unknown etiology, and the absence of a final neuropathologic identification obviously render certain cases of myelitis and allied disorders one of the perplexing diagnostic problems in neurology. In some texts, as Oxford Medicine, there is a tendency to discard myelitis as a heading. In the index of this system there are but two designations of myelitis: one, "compression myelitis," and the other "transverse syphilitic type," neither of which represents a true inflammatory parenchymatous process. The same may be said of traumatic myelitis. Uncontested examples of myelitis are generally expressed by a compounded or definitely-qualified nomenclature, such as poliomyelitis, or suppurative myelitis (abscess). The inflammatory-degenerative cord disorders, often designated as myelopathic states, may be conveniently classified as follows:

1. True inflammatory affections. Examples: poliomyelitis and cord abscess.

2. Demyelinating cord diseases, formerly called myelitis. Subacute combined myelinic degeneration of the cord is an example; multiple sclerosis with predominantly cord localization is another.

3. Vascular diseases with secondary ischemia and anoxemia, leading to softening. Examples: Heubner's syphilitic endarteritis causing so-called transverse myelitis; petechial hemorrhages in concussion.

4. A heterogenous group, as follows:
Landry's paralysis.
Neuronitis.
Guillain-Barré syndrome.
Post-vaccinal myelitis.
Myelitis following antirabic vaccination.
Myelitis in the course of the common eruptive fevers.
Myelitis following injection of foreign serum

LANDRY'S PARALYSIS

The original description of this rapidly-ascending, and often fatal form of paralysis, by Landry[3] (1859) is one of the classics of medical literature. Landry's report of his original case has been translated by Brown.[4] It may be briefly described as a disease of unknown etiology, featured by a rapidly-progressing symmetric ascending paralysis of predominantly flaccid motor type. However, there is some tactile and rather marked, deep sensory loss. The cerebrospinal fluid is normal, there is no rise in temperature. The general condition of the patient appears excellent, and the destiny of the case is decided before cerebral involvement. Death, from respiratory failure, may occur in a week or less. The mortality is high, in the neighborhood of 20 per cent. From this clinical picture, which is essentially that described by Landry, there have been many reported variants, so there is now a tendency to call this myelitic form a type, such as the poliomyelitic type, etc.

The pathology is that seen in noninflammatory and nonexudative myelitis; however, mesodermic infiltration has been reported. Swelling and chromolysis of the anterior horn cells, and degeneration of the white substance, is the usual picture.

NEURONITIS

Classified as myeloradiculoneuritis, this term has been applied to a progressively ascending motor paralysis, associated with sensory changes, deep sensory loss being more marked than superficial. The etiology has not been definitely determined. Kennedy[5] (1919) described the clinical picture. Pathology has been found in the nerves, nerve roots, spinal cord, and also in the motor cerebral cortex. This is degenerative in type, although lymphocytic infiltration has been found in the dorsal root ganglia. Casamajor[6] found edema, hyperemia in the arachnoid, and hemorrhages in the tissue spaces. There is slight if any muscle atrophy. Facial paralysis has been frequently noted. Tendon reflexes are absent or diminished

in intensity. There may or may not be fever. The spinal fluid frequently shows a marked dissociation between cells and protein: without appreciable rise in cell count, the total protein may reach 100 milligrams per cent, or even higher. The fluid in some cases, however, has been reported as entirely negative. Neuronitis has been found to occur after an interval of apparent recovery from an acute respiratory affection. Mortality is between 14 and 20 per cent, but when recovery occurs, it is complete.

GUILLAIN-BARRÉ SYNDROME

This syndrome is very similar to or identical with the foregoing, save for its milder course and lack of definite proof of cord involvement. It has been classified by the authors[7, 8] as radiculoneuritis, and differs from other forms of polyneuritis. It is characterized by a flaccid paralysis of the limbs, usually starting in the lower limbs. A marked cell-protein dissociation is a *sine qua non* of the disease: the protein may reach 1000 milligrams per cent, and the fluid may be xanthochromic. Paresthesias and occasional severe pain are experienced by the onset. Pain is produced by pressure over muscles and nerves. Superficial sensibility is but slightly disturbed, but deep sensation may be markedly affected. The paralysis is flaccid without noticeable muscular atrophy. Fever is generally absent or, if present, but slight. Complete recovery is the rule, although the disease may last weeks or months. The etiology has not been determined, although a virus infection is assumed. De Jong[9] feels that the syndrome should not be restricted to cases in which recovery results, as has been postulated by the authors, and reports two fatal cases in which changes were found both in the anterior horn cells of the cord and the motor nuclei of the medulla.

ACUTE DISSEMINATED MYELITIS (ENCEPHALOMYELITIS)

Under this heading, and keeping in mind the broader conception of the inflammatory process in terms of histopathology, is a group of affections, differing widely in etiology, but having a certain pathologic similarity—scattered lesions predominantly affecting the white substance—and presenting a combination of degenerative and infiltrative changes, the latter often in relationship to blood vessels. Demyelination surrounding small vessels has been called perivascular myelinoclasis. Some of the most common, as well as serious affections, under this classification are the post-vaccinal complications, which may affect either brain or cord: the encephalitic type is more frequent following small-pox vaccination; the myelitic following antirabic vaccination.

Hassin[10, 11] in a number of publications, has described a characteristic pathology of the central nervous system, "multiple degenerative softening," often producing marked cord changes in post-vaccinal, as well as other similar pathologic states, to quote: "It must be postulated that an unknown toxic factor directly attacked the nerve fibers without intermediation of the blood vessels, the process being analogous to the demyelinization produced experimentally by the action of antirabies vaccine extracts of brain, tetanus toxin, potassium cyanide, post vaccinal virus, and toxins from carious teeth, and other factors."

The pathology is a combination of demyelination and inflammatory changes. Islands of degeneration, designated as "soft patches," grossly resemble the firm patches of multiple sclerosis, but on microscopic study nerve and glial fibers are entirely lacking, thus differentiating the pathology from that of multiple sclerosis. These patches are differentiated from softening by occlusion by necrosis and the absence of fibrillary astrocytes and glial scars, although cytoplasmic astrocytes may be abundant. The "soft patches" consist of immense numbers of microgliocytes, most of which are transformed into gitter cells. The inflammatory change is characterized by a predominantly lymphocytic infiltration of the perivascular and adventitial spaces of the blood vessels (symptomatic inflammation of Spielmeyer). Multiple degenerative softening differs from disseminated encephalomyelitis in the exclusively inflammatory reaction of the latter.

POST VACCINAL MYELITIS

Nervous sequelae following small-pox vaccination rarely occur before the second year of life. The symptoms come on in the great majority of cases from the tenth to the thirteenth day after vaccination. There are acute presenting symptoms of headache, pyrexia and vomiting. Cranials, nerves and extremities are involved, the tendon reflexes usually disappear, and the picture is often similar to tetanus because of rigidity and trismus. Convulsions are not uncommon. The duration of the disease is from one to two weeks; the mortality is high, 37 to 58 per cent (according to Russell, in Oxford Medicine). The pathologic picture more nearly resembles acute multiple sclerosis than the encephalitides caused by viruses (Rivers).

MYELITIS FOLLOWING ANTIRABIC VACCINATION

Paralytic accidents usually occur between the tenth and fourteenth day following vaccination. After the initial stage of constitutional symptoms, paralysis of the legs and sphincters rapidly follows. An acute ascending or Landry's type has been described, a dorsolumbar type, and also a cranial and peripheral neuritic type. The mortality is about 30 per cent. When recovery takes place, it is usually complete.

MYELITIS IN THE COURSE OF THE COMMON ERUPTIVE FEVERS

Paralytic complications may occur during or after small-pox, varicella, scarlet fever, and measles. Here, again, there are encephalitic and myelitic types. In the myelitic cases motor paraly-

sis of the extremities, and sensory and sphincter disturbances occur. In measles symptoms usually come on after defervescence and when the patient has fully recovered. The mortality in this complication following measles is approximately 10 per cent; persisting sequelae have been noted in severe cases (Wilson). The pathology has been studied in six cases by Ferraro and Scheffer, who found perivascular proliferation of microglial elements dominantly located in the white substance. Occasionally, there were scattered hematogenous cells. Accompanying this proliferation was a concomitant perivascular demyelination. It seemed evident to these investigators that the noxious agent was carried from the blood vessels to the surrounding tissue. They suggested the term encephalophy, because the pathology was different from the typical inflammatory type.

MYELITIS FOLLOWING INJECTION OF FOREIGN SERUM

In susceptible individuals, this reaction may occur after inoculation of sera, specific or otherwise, but is most often observed after the administration of antitetanus serum, probably because of the frequency of its use. This reaction to foreign serum occurs in the process of sensitization—the patient becomes anaphylactic. Symptoms occur from seven to fourteen days after injection. Generalized symptoms are headache, nausea, vomiting, joint pains, and urticaria. There is a wide variance in the distribution of the nervous lesions. Symptoms referable to the brain, cord, spinal roots, and nerves have been described. Thus, paraplegic and Landry's types have been reported, as well as types resembling multiple sclerosis. The characteristic spinal picture is a paralysis of muscles supplied by the fifth and sixth spinal roots (Erb-Duchenne type of brachial palsy). The pathology predominantly affects blood vessels: vasodilatation, edema, and petechial hemorrhage. Exceptionally, cellular infiltration with necrotic areas in the parenchyma occurs. The spinal fluid may contain a moderate pleocytosis and be under pressure, which symptoms disappear with the urticarial lesions.

CONCLUSIONS

The close resemblance between nervous sequelae following vaccination and following infectious fevers (also serum sickness) has long been recognized. It has been previously suggested that either there is a delayed action of the causative infection, or that the symptoms represent an anaphylactic effect, or that the body is so conditioned by the initial disease as to render it susceptible to other and independent diseases. When attention was first called to the post-vaccinal myelitis, it was thought to be a latent manifestation of epidemic encephalitis.

A close relationship appears to exist between Landry's paralysis, as now reported in the literature, neuronitis, and the Guillain-Barré syndrome. I am convinced that at least neuronitis and the Guillain-Barré syndrome are closely related, and may be identical. Differences in the clinical picture and course may be due to the variations of type and virulence so often met with in virus affections. Landry's paralysis, as clearly defined by Landry himself (assuming that the cerebrospinal fluid was not altered) may be a definite disease entity, or perhaps a deficiency state. This latter is the position of Madeleine Brown. However, in a personal case recently observed, there was no response to large doses of Vitamin B and the patient succumbed. Since the publication of Doctor Brown's article, I have come across no reports of the specificity of Vitamin B therapy in Landry's paralysis.

909 Hyde Street.

REFERENCES

1. Ferraro, A.: Primary Demyelinating Process of the Central Nervous System. An Attempt at Unification, Arch. Neurol. and Psychiat., 37:1100 (May), 1937.
2. Lhermitte: Quoted by Ferraro, loc. cit. Page 1150.
3. Landry, O.: Note sur la Paralysie Ascendante Aigue, Gaz. Hedb. de Méd., 6:472 (Jan.), 1859.
4. Brown, M. R.: Etiologic Study of Landry's Original Case of Acute Ascending Paralysis, Arch. Neurol. and Psychiat., 40:800 (Oct.), 1938.
5. Kennedy, F.: Infective Neuronitis, Arch. Neurol. and Psychiat., 2:621 (Dec.), 1919.
6. Casamajor, L.: Acute Ascending Paralysis Among Troops, Arch. Neurol. and Psychiat., 2:605 (Dec.), 1919.
7. Guillain, G., Barré, J. A., and Strohl, A.: Sur un Syndrome de Radiculonévrite avec Hyperalbuminose du Liquide Céphalorachidien sans Reaction Cellulaire, Bul. et Mém. Soc. Méd. d. Hôp. de Paris, 40:1462 (Oct. 13), 1916.
8. Guillain, G.: Radiculoneuritis with Acellular Hyperalbuminosis of Cerebrospinal Fluid, Arch. Neurol. and Psychiat., 36:975 (Nov.) 1936.
9. De Jong, R. N.: The Guillain Barré Syndrome, Arch. Neurol. and Psychiat., 44:1044 (Nov.), 1940.
10. Hassin, G. B., and Bassoe, P.: Multiple Degenerative Softening Versus Multiple Sclerosis, Arch. Neurol. and Psychiat., 7:613 (May), 1922.
11. Hassin, G. B.: Neuroptic Myelitis Versus Multiple Sclerosis, ibid., 37:1083 (May), 1937.

SELECTIVE ANESTHESIA*

CHAS. J. BETLACH, M. D.
Santa Barbara

THIS paper deals primarily with combinations of anesthetics and methods, and not with single anesthetics which may be the ones selected. Other terms which are used are combined anesthesia, balanced anesthesia (as described by Lundy in 1925), and anoci-association as originated by Crile. Anoci-association is only one type of selective anesthesia, since it consists of a local anesthesia well-fortified by preliminary medication, upon which is superimposed nitrous-oxide and oxygen anesthesia, the essential purpose of which is to destroy consciousness. Whatever the name employed, the idea is to use two or more anes-

* Read before the Section on Anesthesiology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

thetics in minimal amounts, instead of a large dose of one anesthetic which may be dangerous to the patient.

ADVANTAGES OF SELECTIVE ANESTHESIA

Some of the factors which make selective anesthesia safer than large doses of single anesthetics are:

1. Stimuli to the central nervous system are decreased or eliminated, thus diminishing the amount of general anesthesia necessary.
2. The exhaustion caused by nervous tension of some patients under local anesthesia alone is eliminated.
3. Patients having received small doses of anesthetics respond quicker, and normal reflexes return sooner.
4. Large doses of anesthetics, especially spinal for the poor-risk patient, are extremely dangerous.
5. Shock from deep cyclopropane and ether anesthesia is eliminated.

As new agents and methods are introduced, and we become acquainted with them, we gradually work them in with other agents and methods. At the present time a good anesthetist should have enough agents and methods available to carry out almost any procedure with a minimum of risk to the patient's safety. If one method is considered unsafe, it should be discarded for a safer method or combination of methods and agents.

Indications and contraindications for various combinations of anesthetics will not be discussed. Only those combinations with which I am familiar and have found useful on many occasions, will be touched upon. Undoubtedly there are other useful anesthetic combinations.

AUTHOR'S OBSERVATIONS

Selective anesthesia for the bad-risk patient is usually based on local anesthesia: either some type of block or infiltration carried out by the anesthetist, or local infiltration administered by the surgeon. If the surgeon carries out the local anesthetic procedure, it is sometimes necessary to explain to him that, even though the patient is under the influence of a general anesthetic, the local still carries out a definite purpose and should not be abandoned after the first skin infiltration.

Skull and Brain.—Operations on the skull and brain can be carried out under many combinations of anesthetics. In patients with mental stupor or partial unconsciousness, local anesthesia or field block is desirable. Occasionally this type of patient may be uncoöperative, but can be very easily controlled with safety with small doses of 2½ per cent pentothal injected into the vein, or injected with intravenous solutions, or with one of the many special sets of apparatus used for intravenous anesthesia. The effect of the pentothal should be worn off by the time the operation is over. Avertin is not as suitable for this type of patient because of its uncertain action, long duration, and because of the occasional fall of blood pressure which accompanies its administration. After the patient has been controlled at the start of the operation, the pentothal may be sometimes discontinued and the operation carried out under local anesthesia alone. More pentothal may be added, later, if necessary. Some patients object to the administration of the local and here again pentothal may be administered to prevent the pain of the injection and then discontinued after the local is complete.

Avertin, combined with local, serves well for brain operations in patients in good condition. If the avertin and local do not give enough anesthesia, they may be supplemented with intravenous anesthesia. Small amounts of pentothal may be safely added to control the patient. If a free airway is deemed essential for a particular case, it may be necessary to administer nitrous-oxide and oxygen, and possibly a small amount of ether to facilitate easy introduction of the endotracheal tube. An obstructed airway increases intracranial pressure, and a free airway is necessary to permit easy artificial respiration.

Eye.—In operations on the eye when pentothal is to be used, it is helpful to use topical anesthesia also. This seems to prevent some of the sneezing and coughing sometimes encountered.

Teeth.—When pentothal is to be used for extraction of teeth in a noninfected area, a quick injection of novocain-adrenalin solution will cut down on the bleeding, allay some of the immediate postoperative pain, and decrease the total amount of pentothal required.

Thyroidectomy.—For poor-risk patients undergoing thyroidectomy, I feel that local anesthesia again is the basic anesthesia, with the order of anesthesia reversed; that is, the local is given after the patient is unconscious. For the very toxic patient, I prefer either a small basic dose of avertin or intravenous anesthesia administered preliminary to the local. Local anesthesia alone often upsets the toxic thyroid patient. If pentothal is to be used, oxygen should also be given. If it is necessary to awaken the patient during surgery, one may start the anesthesia with pentothal and after a small dose has been administered, nitrous-oxide and oxygen are given and the patient can be awakened at the desired time. Heavy premedication plus local anesthesia is a good form of combined anesthesia which may be satisfactorily used in the nontoxic thyroid in the placid type of individual.

Thoracic Surgery.—For extra pleural thoracic surgery, heavy premedication plus local plus nitrous-oxide and oxygen give a combination which allows the use of the electro-surgical unit. By heavy premedication is meant the use of basal avertin or the usual premedication plus intravenous morphine prior to the administration of the inhalation anesthetic. Both of these combinations are explosion-proof and fire-proof. In some cases the local may be left out and sufficient anesthesia can be obtained without using a more potent agent than nitrous-oxide. For intrapleural work where cautery is to be used, the same com-

bination may be used plus endotracheal intubation.

Abdominal Surgery.—Abdominal surgery offers the greatest opportunity for various combinations of anesthetics. Local infiltration and abdominal block form the basis for selective anesthesia in the poor-risk patient. Abdominal block is preferred because it gives more relaxation of the abdominal muscles. In abdominal block it is important that the solution be injected into the lateral border of the rectus sheath, since it is at this point that the nerves may be most easily reached with some accuracy. Tovell's technique, of making four or five separate injections into the lateral border of each rectus sheath, is one which the surgeon can very easily become acquainted with and use in many cases. This can be done while the anesthetist is administering the general anesthetic. With a good abdominal block, procedures in the abdomen can be carried out in the poor-risk patient with very light general anesthesia with nitrous-oxide, ethylene, cyclopropane or pentothal. If pentothal is to be used, it is wise to give oxygen simultaneously. The addition of nitrous-oxide, not to exceed 50 or 75 per cent, will reduce the amount of pentothal necessary, and still allow good oxygenation to be carried out. Cyclopropane is better if more relaxation is desired. The adrenalin in the local anesthetic should be omitted if cyclopropane is to be used. Spinal anesthesia is not desirable in the poor-risk patient for upper abdominal surgery. Bilateral intercostal nerve block, of the fifth through the eleventh thoracic nerves, is another type of block which gives good relaxation of the abdominal muscles, and may be used instead of abdominal block. However, if it is not done frequently, it is more time-consuming, and means a greater number of needle punctures for the patient to endure.

In the better-risk patient, small doses of spinal anesthesia plus cyclopropane is a very good combination for abdominal surgery. By small doses of spinal anesthetic, I mean not over 135 to 150 mg. of procaine hydrochloride or corresponding amounts of other drugs. The administration of cyclopropane and oxygen permits good oxygenation of the patient and tends to keep the blood pressure elevated, or does not allow the ordinary fall in the usual case. Pentothal may be used in combination with spinal anesthesia to control nausea or produce unconsciousness. However, if the spinal wears off while the abdomen is still open, pentothal may not give enough relaxation for an easy closure. If the blood pressure is low, it is best not to administer pentothal, since it may cause a further fall of blood pressure, and depression of respiration, which may be difficult to overcome. One must be prepared to administer oxygen at any time.

Kidneys.—For operations on the kidney, one of the safest combinations for the poor-risk patient is a paravertebral block of the eleventh and twelfth thoracic, and first and second lumbar nerves, plus infiltration of the line of incision plus pentothal and oxygen, or the block plus cyclopropane and oxygen. Small doses of spinal anesthetic, plus nitrous-oxide or light cyclopropane or pentothal anesthesia, are also very good combinations for kidney operations in the better-risk patient.

CONCLUSIONS

For the poor-risk patient in which the operative procedure cannot be carried out under local anesthesia alone, local or regional anesthesia, and light inhalation or intravenous anesthesia, form the safest combination in a great number of cases. Small doses of spinal anesthetic plus cyclopropane are also a popular method of selective anesthesia.

3023 Serena Road.

CLINICAL NOTES AND CASE REPORTS

EPIDEMIC KERATOCONJUNCTIVITIS: "SHIPYARD EYE"

CLIFFORD KUH, M. D.
Berkeley

SINCE September, 1941, when the epidemic of the keratoconjunctivitis appeared in San Francisco Bay area, there have been occasional outbreaks. Reported cases at this time are relatively mild, and acute symptoms may last a few days instead of several weeks, as was the experience in 1941. Although popularly known as "shipyard eye," cases are by no means confined to shipyard workers.

The onset of the condition is usually sudden. Outstanding symptoms are a sensation of irritation and scratching in the eye, marked lacrimation, slight photophobia, some blurring of vision, and moderate dull pain in the eyeball. Pain and soreness in the preauricular area on the affected side are common symptoms. Many patients also complain of the eyelids sticking together in the morning on awakening.

Physical examination shows the presence of varying degrees of inflammation and hyperemia of the bulbar and palpebral conjunctiva. In severe cases the bulbar conjunctiva is characterized by extreme, glassy edema, and occasionally subconjunctival hemorrhages are present. A thin membrane is sometimes found attached loosely to the palpebral conjunctiva, or lying in the lower cul-de-sac. Neighboring lymph glands and the preauricular gland on the affected side are swollen, and tender in most cases. In some patients who, at first, had only one eye affected, the condition later extends to the other eye.

Some of the individuals who have contracted this condition have developed multiple minute

* A statement by the Bureau of Industrial Health of the California Department of Public Health, Berkeley, California, December, 1942.

opacities of the cornea. In some cases, these are not sufficiently opaque to reduce visual acuity appreciably. However, in other cases there has been a distinct impairment of vision, but the ultimate prognosis for vision is good.

The following precautionary measures have been recommended to plant and shipyard physicians, nurses, and executives to prevent the spread of eye disorders in their establishments:

1. Separate examination and treatment rooms for all eye cases.
2. Provision of medical, nursing or first-aid personnel to work in the eye unit only, and not in the general dispensary or elsewhere in the plant.
3. Thorough washing of hands on part of physicians and nurses within or without the plant before treating next patient, and, if instillations into eye are used, separate eye droppers for each patient with sterilization of droppers after use.
4. Assignment to each worker of personal protective equipment for his exclusive use, such as goggles, respirators and masks, and thorough sterilization of such equipment before transfer to another worker. The placement on a special machine of a pair of goggles for general use of all workers, as is sometimes done, should definitely be discontinued.
5. Instruction of employees in personal hygienic measures, particularly the avoidance of rubbing of eyes with hands; for, in this way, tools, door knobs, etc., may become contaminated. Precautions to be taken at home to prevent the spread of the disease to members of the family, such as use of separate towels and frequent washing of hands, should be emphasized.
6. Removal of the patient from work until he has completely recovered from his conjunctivitis. It is believed this latter measure will reduce total man hours lost by entire plant personnel.

Therapy apparently does not influence course of the disease, but may give symptomatic relief. It is generally agreed that the use of strong antiseptics is contraindicated. Iced compresses, applied for 15 minutes every 2 hours, give more comfort than hot compresses. Constant covering of the affected eye from onset of disease is beneficial. Sulfathiazole or sulfadiazine ophthalmic ointment (5 per cent) is used to prevent secondary infection. Roentgen therapy, irrigation with boric acid or saline solutions, instillations of 2 per cent neoprontosil and other measures have been tried. In the presence of widespread epidemic, it has been suggested that the placing of a guard at the entrance gate of a plant, who would bar all workers with "red eyes," might be considered.

Recent research* incriminates a virus as the causative agent,[1] probably imported by travel from Hawaii. Incubation period is probably 5 to 12 days. It is believed that close contact and direct transfer are necessary.[2] Unknown factors of susceptibility presumably play an important rôle.

2002 Acton Street.

REFERENCES*

1. Epidemic Keratoconjunctivitis, by Murray Sanders, M. D., Archives of Ophthalmology, October, 1942, Vol. 28, page 581.

2. Epidemic Keratoconjunctivitis, by Michael J. Hogan, M. D., and Joseph W. Crawford, M. D., American Journal of Ophthalmology, September, 1942, Vol. 25, page 1059.

TRAUMATIC PERFORATION OF THE BLADDER THROUGH THE RECTUM

FRANK R. GUIDO, M. D.
Visalia

TRAUMATIC injury to the bladder, with rupture or perforation, although relatively uncommon, carries with it a high mortality rate. M. F. Campbell,[1] in 1929, reviewed the records of Bellevue Hospital and found 55 cases of rupture of the bladder in 14½ years, with a total mortality rate of 63.6 per cent.

Perforation of the rectum, or lower sigmoid, by external trauma is seldom encountered, the bulk of such accidents being caused by compressed air held close to the anus. Block and Weissman,[2] in 1926, collected 27 such cases with the high mortality rate of 70 per cent. Since then numerous such reports have appeared in the literature. The seriousness of such accidents is enhanced by the fact that they are usually the result of a practical joke.

The following case report depicts an unusually rare type of injury in which a direct perforation of the rectum and bladder occurred as a result of external trauma through the anus. In a careful search of the English literature, I was able to find the reports of only two similar cases; one of the patients recovered, and the other died. Thompson, quoted by Bailey,[3] relates the case of a schoolboy who fell on an upturned broken chair, the leg of which entered the anus, perforating the anterior rectal wall and passing up through the posterior vesical wall below the recto-vesical fold of peritoneum. Death was due to a virulent infection of the cellular tissues surrounding the bladder and rectum. Ravenel's case[4] was that of a negro who fell on a pick-ax. The sharp end entered the perineum, perforating both the anterior and posterior rectal walls and entering the base of the bladder. Recovery followed the repair of the injured bladder.

Treatment.—Recto-vesical fistula, fecal cystitis and the resulting dire consequences will follow if immediate, efficient treatment is not provided for this type of injury. Adequate treatment consists of transvesical suture of the bladder perforation and suprapubic drainage of the bladder. A tube passing up to the rectal perforation through the anus may be provided, but is not essential, as was demonstrated in the following case report.

REPORT OF CASE

CASE 1.—M. S., male, age 17, whose previous history was irrelevant, was first seen about 5 P.M. on January

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Abstracts of Minutes: California Medical Association Executive Committee*

Minutes of the One Hundred Seventy-ninth (179th) Meeting of the Executive Committee of the California Medical Association

A meeting of the C.M.A. Executive Committee was held in the Association Offices, 450 Sutter Building, San Francisco, on Sunday, December 6, 1942, at 10:00 a. m.

1. Call to Order:

The meeting was called to order by Chairman Rogers with the following members present: Past-President Henry S. Rogers, President William R. Molony, Sr., President-Elect Karl L. Schaupp, Council Chairman Philip K. Gilman, Auditing Committee Chairman John W. Cline, and Association Secretary George H. Kress.

Absent: Speaker Lowell S. Goin, who was out of the State.

Present by Invitation: Harold Fletcher, Chairman, California Committee on Procurement; John Hunton, Executive Secretary; and Hartley F. Peart, Legal Counsel.

2. Minutes:

Minutes of the previous meeting of September 8th were approved by the Council on September 13, 1942.

3. Dr. Harry E. Henderson Elected to Fill 3rd Councilor District Vacancy:

Association Secretary stated that a mail vote of the Council resulted in the election of Doctor Harry E. Henderson, of Santa Barbara, to succeed Doctor Louis A. Packard, resigned as Councilor of the 3rd Councilor District.

4. Membership:

Concerning the recommendation by the Alameda County Medical Association of Retired Membership for Doctor Hubert N. Rowell, it was voted to recommend to the Council that such retired membership should be granted to Doctor Rowell, as of December 1, 1941.

5. Basic Science Initiative:

A brief report was made by Executive Secretary Hunton concerning the Basic Science campaign and results.

A letter was also presented from Mr. John B. Knight, of the California Associated, outlining a form of securing a sample survey from voters in several cities on reasons why they voted for or against the Basic Science Initiative.

The Executive Committee agreed to make no recommendation thereon.

6. Industrial Accident Fee Table: Wage Conference:

Reports were made by Executive Secretary Hunton concerning conferences relating to the Industrial Accident Fee Table and the recent conference concerning wages of employees of doctors and dentists.

* Full minutes of the Executive Committee meeting have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

19, 1941. While tobogganing in the mountains he slid into the underbrush, and a manzanita stick measuring 18 inches long and three-quarter inches in diameter, perforated through the anus. The stick was immediately pulled out. After a two-hour journey the boy was brought into town. He was only in moderate shock, but complained of severe pain in the suprapubic and anal regions. Pulse was 108 beats per minute, and of good quality. Blood pressure was 106/72. Numerous attempts to void were unsuccessful, and a catheterized specimen of urine revealed occult blood. There was no external perineal injury and only a superficial abrasion of the anal margin. The anal sphincter was very spastic; but upon inserting the finger, a perforation 2 cm. in diameter could be felt on the anterior rectal wall about 3 inches from the anal margin.

Treatment.—Preparation was made for immediate laparotomy and under spinal anesthesia the rectum was thoroughly explored. Urine passed out freely through the anterial rectal perforation. No attempt was made to suture the lacerated rectal wall, and no drainage of the rectal area was instituted. A suprapubic midline incision was made and the peritoneal cavity was found unharmed. The rectovesical fold of the peritoneum was not perforated. After closure of the peritoneum, the bladder was opened extraperitoneally. On the posterior bladder wall a perforation of 2 cm. in diameter was found. This was closed with interrupted catgut sutures. The ureteral orifices were unharmed. The bladder was drained suprapubically with a de Pezzer catheter, and a Penrose drain was placed in the suprapubic space of Retzius. The patient was returned to bed in excellent condition.

Postoperative reaction was practically nil, and on the 6th postoperative day one ounce of 2 per cent aqueous solution of mercurochrome was instilled into the bladder through the suprapubic drain. None of the mercurochrome was seen to pass into the rectum. The suprapubic catheter was removed on the 12th postoperative day, and the patient was sent home on the 19th day. At no time did the temperature rise above 100 degrees F. The rectal laceration was completely healed on the 26th day and urinary function was restored to normal on the 24th day.

COMMENT

The possibility of bladder perforation must be constantly kept in mind when dealing with penetrating wounds of the lower abdomen or in the region of the anus. The presence of occult blood in the urine, although not pathognomonic, is of the highest diagnostic significance. Failure to recognize such a bladder perforation at once will result in delaying adequate treatment, with its subsequent mortality rate of close to 70 per cent. The essence of treatment consists of transvesicle suture of the bladder perforation. Suture of the rectal wall and drainage of the area of rectal perforation are not necessary.

310 West Willow Street.

REFERENCES

1. Campbell, M. F.: Rupture of the Bladder, S.G.O., 49:540-546 (Oct.), 1929.

2. Block, F. B., and Weissman, M. I.: Jour. A.M.A., 1926, 86, 1597.

3. Bailey, Hamilton: Emergency Surgery, Williams and Wilkins Co., 1940.

4. Ravenel, James J., Traumatic Rupture of Both Walls of the Bladder and Rectum, The Journal of Urology, Vol. 37, No. 6, p. 796.

REFERENCES

References which follow are continued from article on Bronchoscopy (see pages 10-11).

1. Clerf, L. H.: Ann. Int. Med., 9:1051, 1936.

2. Miller, H., Piness, G., Finegold, B. F., and Friedman, T. B.: J. Pediat., 7:768, 1935.

3. Prickman, L. E., and Moersch, H. J.: Bronchostenosis and Asthma, Ann. Int. Med., 14:387, 1940.

4. Huber and Koessler, quoted by Boyd in his Pathology of Internal Disease, 1931, page 138.

5. Moore, W. F.: The Cilliary Inhibition or Destruction in Bronchial Asthma, Tr. Am. Acad. Opth., 29:333, 1924.

6. Weille, F. L.: Studies in Asthma, N. Eng. J.M., 25:848, 1931.

7. Wilmer, H. B., Cobe, H. M., and Lee, W. E.: Ann. Surg., 91:651, 1930.

8. Tucker, G.: Bronchoscopic Observations on Obstructive Pulmonary Atelectasis, Arch. Otolaryng., 13: 315, 1931.

9. Peshkin, M. M., and Fineman, A. H.: Acute Massive Atelectasis and Asthma, Amer. J. Dis. of Child., 42:590, 1931.

10. Kahn, I. S.: Texas State J. of Med., 28:416, 1932.

11. Maxwell, J.: St. Barth. Hosp. Rep., 70:183, 1937.

12. Lukens, R. M.: Bronchoscopy in Treatment of Asthma, Laryngoscope, St. Louis, 35:227, 1925.

MEDICAL EPONYM

Queckenstedt Maneuver

The contribution, "Zur Diagnose der Rückenmarkskompression [Diagnosis of Spinal-Cord Compression]," from which the following extract is taken, appeared in the *Deutsche Zeitschrift für Nervenheilkunde* (55:325-333, 1916). The author, Hans Queckenstedt (d. 1918), was then *Privatdozent* and *Oberarzt* in the University Medical Clinic at Rostock.

"Wherever the dural tube is thus damaged, an exchange of spinal fluid between the two spaces thereby engendered is impossible. But even in lesser degrees of the condition described, the narrowing of the passageway must offer increased resistance to any movement of the fluid. Consequently, if there occurs any increase in pressure above the point of compress, the fluid either will fail absolutely to be displaced caudally or will do so with diminished rapidity, according to the degree of block. Such an increase in pressure may be effected in a simple manner, by vigorously grasping and compressing the throat either on both sides or unilaterally. The space available for the fluid is diminished from within by the excess of blood in the brain, and possibly from without as well, by the equalizing efflux of blood through the upper vertebral venous plexuses, thereby occasioning an increase in pressure, which is normally transmitted downward very quickly and reveals itself in a vertical tube attached to the lumbar-puncture needle. The beginning of the rise of the fluid in the tube follows almost immediately the compression of the neck, in less than one second, and the fluid rises very quickly with a kind of spurt until it reaches a momentary maximum. One soon acquires an idea of the normal interval after performing the test a few times. In the presence of compression, the rise is slow, and above all, the onset is delayed; frequently, it is necessary to produce marked congestion to obtain it at all, and in turn, on removal of the pressure about the neck, the pressure falls abnormally slowly or not at all."—R. W. B., in *New England Journal of Medicine.*

Life, if thou knowest how to use it, is long enough.
—Seneca, *De Brevitate Vitae.* Sec. II.

13. **Roll Call:**

Present: Henry S. Rogers, Chairman; Karl L. Schaupp, John W. Cline, and George H. Kress.

Absent: William R. Molony, Sr. (in Washington, D. C.); Philip K. Gilman (ill); and Lowell S. Goin (excused).

Present by Invitation: H. Gordon MacLean, M. D., Theodore C. Lawson, M. D., and S. A. Jelte, M. D., all of Oakland, and members of the Board of Directors of Hospital Service of California; also present, Executive Secretary John Hunton; Dr. Harold Fletcher, Chairman of Procurement and Assignment Service of California; and Legal Counsel Hartley F. Peart.

14. **Alcohol for Hospitals:**

A letter of December 10th, received from the Association of California Hospitals, called attention to the fact that hospitals were not included in the preferential group under amended order of the W.P.B.—M-30, with respect to the use of ethyl alcohols and related compounds, it appearing that "small hospitals which do not have tax free alcohol permits because of limited diagnostic facilities, scientific work and laboratory procedures, and these would fall within the restrictions and are threatened with being deprived of the necessary quantities of alcohol."

It was voted that a letter should be forwarded by the Association Secretary in line with the suggestion made by the Association of California Hospitals.

15. **A Revised Fee Table for the Industrial Accident Commission:**

Report was made that present indications pointed to adoption of a new and extensive fee table to cover medical, surgical, and related services coming under the jurisdiction of the Industrial Compensation Law of California. It was stated that representatives of the Commission had shown a kindly interest in the plan and it was hoped that the new fee table would shortly become operative.

16. **California Physicians' Service and Hospital Service of California:**

The meeting was then thrown open for informal exchange of opinion between members of the C.M.A. Executive Committee and medical members of the Board of Directors of Hospital Service of California. Doctor MacLean, President of the Board of Directors of Hospital Service of California, outlined a brief history of the negotiations that had taken place in the past, stating that the medical members of the new Board of Directors of H.S.C. were most anxious to bring about a happier arrangement than has existed in the past. Unfortunately, the letter of November 16, 1942, which had been sent to Hospital Service by California Physicians' Service, indicated that it would not be possible to carry out some of the changes which the Board of Directors of Hospital Service of California had in mind.

The disadvantages of duplication in management, particularly in reference to procedures for acquisition of beneficiary members were commented upon. It was stated that Hospital Service of California had no desire to sell medical contracts and that only one of such, and that to a very small group, had been sold at the time when the recent break in Alameda relations took place.

Frank exchange of opinion was made concerning the unfortunate situations which had arisen through personalities. It was felt that such incidents could be avoided in the future.

Doctor Harold Fletcher, Chairman of the Procurement and Assignment Service of California, was called on to discuss the matter from the broader aspects of medical needs of the military forces and for the essential, or war industries. Doctor Fletcher emphasized the great importance of clearing up the situation, because, otherwise, the Government would be more than apt to promptly step in and set up an organization of its own that might endanger medical practice as it is now being carried on.

President-Elect Karl L. Schaupp, who is a member of the Executive Committee of the C.M.A., and also a member of the Board of Directors of Hospital Service of California, explained his understanding of the situations that had arisen.

Motion. Upon motion by Schaupp, seconded by Cline, it was voted that the Executive Committee recommend that the Council of the California Medical Association request California Physicians' Service to again make contacts with Hospital Service of California to the end that the best interests of medical and hospital service in California be promoted and unified.

During the discussion, Doctor Cline telephoned the offices of Doctor Alson Kilgore and Doctor T. Henshaw Kelly, of the Board of Trustees of California Physicians' Service, to learn whether they could come over to the meeting. Doctor Kilgore was not in the city, but Doctor Kelly stated he would join the group at luncheon.

At the luncheon, a further discussion of ways and means to bring about an improvement in relations between C.P.S. and H.S.C. took place, the conversations being very frank and cordial by all who took part.

Doctor Kelly was informed of the prior action of the C.M.A. Executive Committee and stated that he, himself, would promptly write to members of the Board of Trustees, urging California Physicians' Service to again resume relations with Hospital Service of California.

It was agreed that the consideration of details and of items that had been discussed should be left for later conference between the two organizations, and that it would be desirable to bring the same into operation, if possible, through a gradual process of evolution, rather than through radical readjustment.

17. **Adjournment:**

There being no other business, the meeting was adjourned.

HENRY S. ROGERS, *Chairman.*
GEORGE H. KRESS, *Secretary.*

WARTIME INDUSTRIAL SERVICES

With Special Comment on the Permanente Foundation, California Physicians' Service and Procurement and Assignment Service

Some Factual Information

FOREWORD

So many verbal fireworks were touched off at the recent Pepper subcommittee hearings in Washington that a review of the Kaiser medical situation in California is advisable at this time. Particularly is it important to analyze the Kaiser medical care plan and to consider it alongside the existing medical care facilities in the area where it works. The part of Procurement and Assignment Service in this picture is also worthy of mention.

Without going into the history of America's entry into the present war it is well to bear in mind that the Kaiser Company was building ships for Great Britain in its Richmond yards before this country had fired a shot. The company was also planning its expansion into United States Maritime Commission ship building in additional yards in Richmond.

Under California's industrial accident compensation

7. Nominees for Advisory Council of Board of Nurse Examiners of California:

The Board of Nurse Examiners of California having made request for four names of members of the California Medical Association, two of whom would be appointed to their Advisory Council, it was agreed that such names should be sent. (Note: William R. Molony and Karl F. Schaupp were appointed.)

8. Hospital Service of California: Its Proposal to Sell Surgical Indemnity Contracts:

A letter of November 27th, addressed to Council Chairman Philip K. Gilman and signed by the Hospital Service of California, with enclosures of a letter of October 28, 1942, addressed to C.P.S. Executive Committee Chairman T. Henshaw Kelly, and a letter of November 16, 1942, addressed to the Board of Directors of Hospital Service of California and signed by Trustees of California Physicians' Service, were then taken up for consideration.

A detailed history of the issues involved was given by Doctor T. Henshaw Kelly. Discussion was participated in by Doctor A. E. Larsen, Secretary of C.P.S., and Mr. Peart and others.

Doctor Karl L. Schaupp, a member of the C.M.A. Executive Committee and also a member of the Board of Directors of Hospital Service of California, outlined his understanding of the events that had taken place. Doctors Molony, Cline, and Rogers took part in the further discussion.

Doctor Schaupp brought out the point that the four medical members of the newly-elected Board of Directors of Hospital Service of California had expressed a desire that the unfortunate circumstances which had arisen between California Physicians' Service and Hospital Service of California should, if possible, be ironed out in amicable fashion, and expressed regret that the letter of November 16, 1942, was of a nature to almost prevent further negotiations.

After further consideration, the Executive Committee voted that it would be desirable to recess the meeting, to meet again in the C.M.A. Offices, on Sunday, December 13th, and that an invitation be extended to the four medical members of the Board of Directors of Hospital Service of California (H. Gordon MacLean, M. D., Theodore C. Lawson, M. D., S. A. Jelte, M. D., and Karl L. Schaupp, M. D.) to meet with the members of the C.M.A. Executive Committee to discuss informally the subjects and activities in which the two groups have mutual interests.

Mention was also made of a confidential bulletin that had been sent out by the Medical Administrative Service of New York on hospital service conditions in California. Some interesting information was submitted in regard thereto.

9. Procurement and Assignment Service Report:

Doctor Harold A. Fletcher, Chairman of the California Committee on Procurement and Assignment, who was present by invitation, submitted a report concerning the present status of the work of Procurement and Assignment. He pointed out that the Permanente Foundation Medical program of the Kaiser Shipbuilding Company in Richmond is doing a very excellent job in providing industrial accident and health care for the employees of the Kaiser Shipbuilding Company, and that the Permanente Foundation owned and maintained a hospital with complete hospital and ambulance services. The staffing of this hospital and medical service has antedated the work of Procurement and Assignment, in that there were a large number of physicians on the staff who should be eligible for the military forces. With Procurement and Assignment Service gradually working out the re-placement of these physicians with Doctor Sidney Garfield, the Medical Director of the Permanente Foundation, he further pointed out that there would be a probable duplication of medical services, if, as, and when the California Physicians' Service took over the Federal Housing Projects in the Richmond area. He felt that it was very necessary that California Physicians' Service work in coöperation with the Permanente Foundation, and that with proper coöperation on both sides, a re-duplication of services should be avoided during the present emergency. He also expressed the opinion that California Physicians' Service should look forward to greater expansion, particularly in the care of employees and employees' families in industrial expansion areas, other than those covered by Federal Housing Projects, and that C.P.S. might even have to consider taking over industrial coverage, as well, in certain areas.

The Executive Committee received the report by Doctor Fletcher, but made no recommendations thereon.

10. Recent State Election:

Informal discussion took place concerning the State election, held on November 3, 1942, in connection with Basic Science and other matters in which the medical profession was interested.

11. Annual Session:

The Association Secretary, as Chairman of the Committee on Scientific Work and as Editor of CALIFORNIA AND WESTERN MEDICINE, for which articles would be needed, called attention to the newspaper reports of the preceding day (December 5th) in which it was definitely stated that the U. S. Navy would take over the Hotel Del Monte as a Pre-Flight School before December 31, 1942.

Discussion then took place on whether an annual session with both scientific and business meetings should be held and, if so, when and where?

On motion by Cline, seconded by Schaupp, it was voted as follows:

Resolved, By the Executive Committee that it be recommended to the Council, that the 1943 Annual Session shall be a streamlined, two-day session, commencing on Sunday morning, May 2, 1943, through Monday, May 3, 1943; and that the session be held in the City of Los Angeles, with headquarters at Hotel Biltmore.

It was also agreed that this recommendation should be called to the attention of the members of the C.M.A. Council, through an informative letter with reply blanks, so that a mail vote could be taken thereon.

(Note: By mail vote, the Council approved the plan as outlined in the resolution.)

12. Recess Until December 13, 1942:

President Molony stated that it would be necessary for him to be present at a meeting of the War Committee of the A.M.A. which would be in session over next week-end in Washington, D. C. President-Elect Schaupp stated it might be necessary for him to be away in the succeeding week. Motion was, therefore, made and carried that the Executive Committee recess until 10:00 a. m. on Sunday, December 13th, at which time unfinished items on the docket and new business could be considered, and on which day the informal conference could be held between members of the Executive Committee and the four medical members of the Hospital Service of California.

* * *

RECESSED MEETING OF DECEMBER 13, 1942

On Sunday, December 13th, the recessed meeting of the Executive Committee was held in the offices of the California Medical Association, 450 Sutter Building, San Francisco.

laws the company was required to give medical care to injured employees. This was done under a plan by which several commercial insurance carriers handled the industrial accident liabilities. Full time physicians were employed for the joint insurance carriers to staff the field hospital and the five first aid stations. The field hospital and first aid stations were built by the Maritime Commission in the old and new Richmond shipyards. The equipment, ambulances and supplies were furnished by the Kaiser Company.

This process had been going on for several months before Procurement and Assignment Service was established.

To bring the picture up to date, there are now about 87,000 employees at the Richmond yards. The medical care of these employees for industrial accidents alone requires a staff of physicians, nurses and first aid workers.

With the tremendous expansion of employment rolls in the shipyards doing Maritime Commission work there came to the Maritime Commission a new sense of responsibility for keeping the men on the job, keeping the ships sliding down the ways. Officials of the Commission in Washington went to work on various plans for the extension of medical care to cover nonindustrial as well as industrial illnesses of these employees. The theory behind this movement was that readily available medical care for everyday illnesses and injuries would result in keeping men on the job, or getting men back on the job in faster time, and would thereby save man-hours for essential war production.

The Commission reportedly approved the Kaiser plan of setting up a medical care program for Kaiser employees. This plan, working on the proceeds of a 50-cent weekly payroll deduction, was designed to give complete medical care and hospitalization to Kaiser employees who were injured or taken ill from nonindustrial causes.

That plan is now in operation, covering some 52,000 employees at the Richmond yards who have agreed to the 50-cent weekly payroll deduction. These employees have available to them the facilities of the Maritime Commission field hospittal and six first aid stations. They also have available a staff of close to fifty physicians, a 78-bed hospital in Oakland and full nursing and accessory services.

The plan is operated by Sidney R. Garfield, M. D., who has contracted to furnish medical care to Kaiser employees. The digest of the plan furnished to employees states that the "shipyards have agreed to make weekly deductions for the employees who have subscribed and on behalf of such employees to pay the amount deducted [50 cents weekly] to Dr. Garfield."

The combined plan of industrial accident cases and nonindustrial medical cases has the following resources: The Maritime Commission provides a field hospital and six first aid stations. Mr. and Mrs. Henry Kaiser have provided over $500,000 for the Permanente Foundation and with this money have bought, rebuilt and renovated the old Fabiola Hospital of 78 beds and equipped it with complete modern facilities; a new additional wing of 75 more beds is now being added.

They have equipped the Maritime Commission-owned field hospital, now being expanded, to treat a large number of industrial as well as nonindustrial conditions near the plants and to provide temporary bed care for serious emergency cases. Complete medical, nursing, ambulance and therapeutic services are combined in this Field Hospital. The income to meet current expenses and to amortize the loan from Mr. and Mrs. Kaiser comes from the industrial medical fees paid by the insurance companies plus the 50-cent weekly subscription fees from employees subscribing to the Health Plan.

Statements made by Dr. Garfield and others associated with Mr. Kaiser indicate that the Permanente Foundation is a nonprofit venture. It is anticipated, these people say, that eventually the foundation medical plan will make a profit out of current operations; at that time it is planned that all profits shall accrue to the repayment of the $500,000 advanced by Mr. and Mrs. Kaiser. When that sum has been repaid in full, any further profits will be used for the promotion of medical research, for the rehabilitation of disabled physicians, for the endowment of hospital beds, for the teaching of industrial medicine and for other professional advancement.

Dr. Garfield, according to these statements, is employed under an agreement which allows him to draw up to $25,000 annually in salary. To date, he states, he has drawn no salary from the funds of the Foundation but has actually put into current operating funds some $10,500 of his own money. When and if the profit period of the Foundation is realized, it is anticipated that Dr. Garfield will draw his $25,000 annual salary, will be repaid his $10,500 advance and will have no further share in any profits accruing from the plan.

An inspection of the Permanente Foundation facilities by qualified physicians has disclosed that an up-to-date medical service of unquestioned merit is being performed. Hospital and treatment facilities are excellent and a well qualified and well paid staff of physicians is available for any kind of medicine or surgery. From the standpoint of the present emergency and the rapid expansion in the Richmond area this complete industrial and health service is doing a necessary job which could not have been done nearly so effectively with the medical facilities existing when it was set up.

With the present tremendous loss of physicians to the armed forces it is absolutely necessary to pool and concentrate the remaining medical manpower to cover such industrial needs. The Kaiser plan is one answer. Whether it will pay itself out during the present emergency and what will happen after the emergency when such expansions shrink gradually or rapidly, are questions that remain at present unanswered.

California Physicians' Service

California Physicians' Service, a nonprofit medical care organization sponsored by the doctors themselves through the California Medical Association, has also entered into the health care of wartime industrial employees in shipyards and other areas. All ethical licensed physicians in California, whether or not they are members of the County or State Medical Societies, are eligible for the staff of C.P.S.

The approach of C.P.S. to this problem has necessarily been different from the approach of Mr. Kaiser, particularly since there is no chance for C.P.S. ever to reach a stage where profits from its service will accrue and will be available to amortize the cost of facilities. There is also the consideration that C.P.S. is a Statewide organization dealing with numerous groups of employed persons and responsible for the health of nonwar industry employees: Mr. Kaiser, on the other hand, is concerned only with one group of employees, albeit a large one. It is also to be noted that C.P.S. could not have the resources with which to erect new hospitals, and has not considered entering the field of industrial accident services and therefore has not this rich source of income.

California Physicians' Service has contracted for the medical care of the shipyard and other industrial em-

ployees on an area basis. Outside the industrial plants its services are being rendered employees and their families residing in the Federal Housing Authority projects built around the industrial plants. C.P.S. operates a medical center in each of the housing areas it serves; staff physicians and nurses at the medical centers give immediate care to the industrial employees and their families, referring to professional members of C.P.S. in the immediate vicinity those cases requiring hospitalization, surgery or more extensive medical care. In each case the local county medical society has consented to this arrangement and a local medical advisory committee has been established.

The Federal Public Housing Authority adds the monthly charge for C.P.S. services to the rental of the housing units and turns over these collections to C.P.S.

When and if a profit should accrue from C.P.S. services in the housing areas, such a profit must be returned to the subscribing employees and their families in the form of either reduced fees or increased services.

The cost of hospitalization is included in the C.P.S. fee.

Procurement and Assignment Service

Procurement and Assignment Service has been brought into the picture through its responsibility to civilian and industrial populations in preventing too great a loss of physicians to the military forces, and in causing proper redistribution and reallocation of physicians to areas where needed.

The one problem of Procurement and Assignment Service in this matter is the problem of meeting military quotas and at the same time directing to essential industrial organizations or to areas which are short of doctors, those physicians who cannot qualify for military service but who can give medical care to the civilian population. In its reallocation program Procurement and Assignment Service operates as an advisory body only; it has no authority to order any physician to change his location.

Early in its existence in California, Procurement and Assignment Service became aware of the building up by Mr. Kaiser and Dr. Garfield of a staff of physicians for both the industrial and nonindustrial medical care of Kaiser employees. The Kaiser staff of some thirty physicians (early in 1942), represented a group of young men, all but two of whom were definitely of military age.

A review of the Kaiser medical staff showed that practically every one of the thirty physicians should be declared "available for military service" because of his age; at the same time, Procurement and Assignment Service had no intention or desire to break up an established staff which was caring for an important segment of the industrial population.

Complaints had been heard from the medical profession that the Kaiser staff was practising "corporate medicine," that Dr. Garfield had resorted to "piracy" in hiring his physicians, that the whole operation was an unethical one, that doctors eligible for military service were being offered sanctuary and protection from Selective Service. Procurement and Assignment Service took the attitude, however, that its function had nothing to do with ethics and that its approach to the problem must be from the point of view of the distribution of physicians between military and civilian agencies.

At the same time, Procurement and Assignment Service put Dr. Garfield on notice that his staff members were vulnerable to induction into the Army by Selective Service because of their low average age. This warning was given for the protection of the staff, to obviate the disruption that might occur if a large part of the staff was classified 1-A by local draft boards and forced into military service.

On the basis of the above reasoning, a program was worked out whereby Dr. Garfield would clear through Procurement and Assignment Service any physicians who were under consideration for employment on his staff. It was understood that those physicians who otherwise would be available for military service were not to be employed by Dr. Garfield except for a temporary period, while they awaited the issuance of their commissions and orders for active duty.

A second part of this program called for the replacement of any four young staff members every ninety days; replacements were to be by physicians over military age or physically disqualified and rejected for military service. Procurement and Assignment Service agreed, under this program, to declare "essential" the remaining members of the Garfield staff until the time for replacement of each staff member should come up.

This program was put into operation. Procurement and Assignment Service has referred to Dr. Garfield no less than 25 physicians who are either too old for military service or have been rejected by the Army. Some of these have been acceptable to Dr. Garfield and have been employed by him; some have been unable to perform the medical duties with satisfaction. Nine of the former members of the Garfield staff have been accepted for military duty and have been replaced by other physicians. The program is somewhat behind schedule at present because Dr. Garfield found it necessary shortly after the start of the program to increase his staff to care for the increasing number of employees who have signed up for the plan, and to cover the expanding program of the shipyards. To accommodate this larger group of employees a 75-bed addition is being built onto the Permanente Hospital in Oakland; priorities for building materials were secured by the Maritime Commission on the ground that service was being rendered to employees of a Commission shipyard.

Today, from the point of view of Procurement and Assignment Service, the Permanente Foundation is rendering an excellent medical service to Kaiser employees. California Physicians' Service is likewise rendering an excellent health service to industrial employees and their families in the defense housing areas. The problem of Procurement and Assignment Service now is to see to it that there is not an overlapping, a duplication, of medical care facilities.

Questions Needing Answers

In the case of Richmond, can the Kaiser employees receive adequate medical and hospital care from other physicians in the vicinity?

How wide an area is the residential area of the 85,000 Kaiser employees?

How many civilian physicians are there in that area, ready, willing and able to take on the private medical care of these employees and their families?

Is Dr. Garfield going to expand his plan to include the families of employees? So far he has not done so but it is known that Mr. Kaiser has offered such coverage on previous construction projects and is likely to do so again.

Is Dr. Garfield going to expand his plan of employing civilian physicians on a part-time basis to give medical care to employees who live outside the reasonable service area around the Permanente Hospital in Oakland? He has already employed one San Francisco physician to make house calls.

Will California Physicians' Service and Dr. Garfield

be able to work out a joint program of rendering medical care to shipyard workers and their families?

What solution will be reached where the shipyard employee is paying 50 cents a week for the Kaiser medical service and finds that by living in a Federal Housing Authority housing project he is getting full medical care from C.P.S. for himself and his family? How will the overlapping of medical services in such a case be eliminated for the conservation of medical resources?

Will there be a further overlapping of medical services if Mr. Kaiser's suggestion of industry sponsoring medical foundations is generally followed on a statewide or nationwide scale?

* * *

These are some of the problems of today in regard to the Kaiser service. Entirely aside from considerations of ethical medicine, these problems exist as economic factors in the efficient distribution of medical resources. With military demands for physicians rising higher every day, with industrial employees increasing in number, with the need for a scientific utilization of all medical resources in order to make a little bit of material go a long way, these questions demand an answer.

Bit by bit, these questions are being answered by Procurement and Assignment Service and by others. Little by little the problems are being clarified, although much remains to be done before the situation will be entirely straightened out.

One thing, however, remains certain. Whatever solution to this problem is finally worked out, it must be along lines which will permit the most efficient use possible of all medical manpower.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals—For Colleagues in Military Service:

In this issue appears editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

This notice will appear in this department every month.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261).

OFFICIAL NOTICE: IMPORTANT

(COPY)

Office for Emergency Management

WAR MANPOWER COMMISSION

Procurement and Assignment Service for Physicians, Dentists, and Veterinarians

Washington, D. C., November 15, 1942.

Dr. George H. Kress, Editor,
450 Sutter St.,
San Francisco, California.

Dear Doctor Kress:

The Directing Board of the Procurement and Assignment Service suggests that you publish the following statement in some prominent position of your OFFICIAL JOURNAL. The Board deeply appreciates the support, help, and coöperation always received from you:

"It is of the utmost importance that the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, immediately has the name of any doctor who really is willing to be dislocated for service, either in industry or in over-populated areas, and who has not been declared essential to his present locality.

"This is necessary if the medical profession is to be able to meet these needs adequately and promptly.

"We urgently request that any physician over the age of 45 who wishes to participate in the war effort send in his name to the State Chairman for the Procurement and Assignment Service in his State."

Sincerely yours,
(Signed) FRANK H. LAHEY, M. D.
Chairman, Directing Board.

New Method of Blood Transfusion

A new method of blood transfusion promises more effective treatment for men wounded on the fighting fronts, the journal of the American Medical Association recently announced.

The journal said the discovery that albumin in blood plasma (the liquid part) could be injected in more concentrated form than whole plasma provided "a new method of great effectiveness for combating shock from injuries, hemorrhage and burns."

The method was said to be particularly important for treating wounded on the battlefield to reduce the mortality from shock. Doctors using the albumin serum would need it in quantities only one-fifth as large as those required if whole plasma were used, the journal said. Hence its use would facilitate shipping, storage and administration.

California P. and A. Service

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone EXbrook 3386, Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

Life Insurance for Physicians in Service

A physician who enters the service would naturally ascertain the status of his life insurance policies. He should first find out from a perusal of his policies in force whether they have a war risk exclusion clause. Policies written since the fall of 1941 contain such clauses.

Some physicians cannot maintain their life insurance programs while in the service without borrowing. Physicians should know that according to the Soldiers and Sailors Civil Relief Act of 1940 those in service can obtain a moratorium on premiums on life insurance policies not in excess of $5,000 taken out before October 17, 1940, the date of the approved act.

In order to take advantage of this moratorium a Veterans Administration Insurance Form No. 380 should be filled out and sent to the insurance company and a copy to the Veterans Administration. The Veterans Administration will issue a certificate of the U. S. Treasury to the insurance company to cover all deferred premiums.

As in World War I a man in service may take out a government term policy which will terminate in five years unless converted before the end of that period. This policy makes no provision for total or permanent disability as in 1917, but does provide for waiving of payment of premiums during continued total disability.

It is perhaps unnecessary to advise physicians to apply for a government life insurance policy on entering service, to take effect immediately.

Revised Instructions for Field Casualty and Ambulance Units of the Emergency Medical Service

(COPY)

OFFICE OF CIVILIAN DEFENSE

Washington, D. C.

Circular: Medical Series No. 23

TO: Regional Directors and Regional Medical Officers.
FROM: JAMES M. LANDIS, *Director.*

DR. GEORGE BAEHR, *Chief Medical Officer.*

Because of the diminishing supply of civilian physicians and nurses and the growing necessity to conserve manpower, the following economies in the organization and operation of field units of the Emergency Medical Service are to be recommended to all State and local Chiefs of Emergency Medical Service for adoption:

1. *Mobile Medical Teams.*—Emergency Medical Field Units are to be composed of mobile medical teams and no longer of squads or groups of teams. Each mobile medical team is to consist, as heretofore, of one physician, one nurse, and two auxiliaries.

2. *Express Parties.*—Immediately upon receiving an air raid warden's report of a bombing incident with casualties, the Control Center will dispatch only one Express Party to each major incident. An Express Party will consist of one Rescue Team, one Mobile Medical Team, one ambulance, and perhaps one passenger car or station wagon.

3. *Reserves.*—Such an Express Party will usually be sufficient to handle a major incident or a group of neighboring minor incidents with casualties. Additional medical and rescue personnel, ambulances, and passenger cars for sitting cases should be held in reserve and should be dispatched by the Control Center only upon subsequent request of the incident physician (head of the mobile medical team) or of the incident officer at the scene.

4. *Reduction in Movement and Use of Medical Personnel.*—Mass air raids have occurred chiefly, although not exclusively, at night; both night and day raids are now usually sudden and intense. As protection against a sudden and unexpected attack by the enemy, every hospital having interns or residents is urged to have at least one or more mobile medical teams constantly on call so as to be ready to respond promptly to the order of the Control Center. Most alarms are not followed by an enemy attack; the availability of a few mobile teams at each hospital will make it unnecessary in most cities to disturb the depleted and overworked medical profession by requring them to mobilize at casualty stations throughout the city on every alert. Moreover, the first line mobile medical teams of hospitals also need not be disturbed until medical service is needed at an incident where casualties have been reported. Practicing physicians of the neighborhood should be mobilized to relieve the primary mobile team when there is a continuing need for field services at the incident, or when multiple or large incidents make it desirable to activate a casualty station for the care of the slightly injured. Conservation of medical personnel in this manner will, from now on, become increasingly important.

5. *Reduction in Number of Casualty Stations.*—Conservation of emergency medical service personnel can also be accomplished by reducing the number of casualty stations which must be equipped and staffed. British experience over three years indicates that most cities do not require more than one casualty station for each 25,000 persons and that they need not be nearer than a mile apart. Casualty stations for the temporary care of minor casualties are required at or near every hospital. They are also required in parts of a city a mile or more from a hospital and in sections which are geographically isolated. Every community is requested to reëxamine its casualty stations in the light of these requirements and to eliminate all unnecessary locations.

6. *Economy in the Use of Casualty Stations.*—Casualty stations need not be activated in areas where no casualties have been reported. A mobile medical team should always be available at hospitals to activate its casualty station when necessary. A mobile medical team should be dispatched or assembled at casualty stations near incidents only when casualties have been reported in that vicinity.

The mobile team for a casualty station located at a hospital is, therefore, best derived from the hospital; a mobile team for emergency service at casualty stations remote from hospitals should be derived either from a hospital, if within three miles, or from the physicians, nurses, and auxiliaries residing in the neighborhood if more than three miles away or otherwise geographically isolated.

7. *Central Control.*—The Chief of Emergency Medical Service or his deputy at the Control Center will keep a record of all hospital mobile teams and ambulances in his district and of physicians, nurses, and auxiliaries living in the vicinity of each casualty station, who are on call for emergency service. He will determine when to dispatch a mobile medical team from a hospital to an incident or to activate community medical personnel for service at an incident or casualty station.

8. *Elimination of Advanced First Aid Posts.*—All fixed first aid posts can be eliminated. Experience has shown that under the conditions of darkness, confusion, and dirt that exist at air raid incidents, it is rarely necessary or even possible to establish a temporary first aid post. In the darkness and dirt it is impossible to do much more for air raid casualties on the spot than cover their wounds, control hemorrhage, apply a simple splint, and administer morphine before they are removed to the hospital. Most of this work has already been done by rescue workers and the incident physician by the time the casualty is extricated. Only at a large incident with many casualties may it be desirable to esablish a first

aid post at an appropriate protected site. Even under these circumstances, it should be used as a base of operations for medical personnel rather than a place where severely injured casualties are brought for treatment.

9. *Rescue Units.*—Services of Stretcher teams are required at hospitals for unloading of ambulances. Stretcher teams (and so-called first aid parties) are not required in the field, for whatever first aid is possible at incidents is done by the trained rescue workers under the direction of the incident doctor. To conserve manpower, stretcher teams may be disbanded as soon as the rescue teams have been organized and trained, or they may be transferred to the rescue service. The equipment of a rescue team will hereafter include four stretchers. An intensive training program for rescue workers will be announced shortly.

10. *Ambulance Units.*—To reduce the movement of vehicles during an air raid, to economize in driver personnel, and to expedite the transport of large numbers of serious casualties from the incidents to hospitals, as many ambulances as possible should be remodeled so as to enable them to carry four stretchers. The use of one- and two-stretcher vehicles greatly delays the movement of large numbers of casualties to hospitals and may result in needless loss of life. To provide adequate transportation of casualties in mass air raids, exposed cities in the target areas require at least one four-stretcher ambulance for every 10.000 persons, depending upon the location of hospitals and the distances to be covered, and half that number of passenger cars or station wagons for sitting cases. Specifications for the conversion of used cars into four-stretcher ambulances will be provided by the Medical Division, United States Office of Civilian Defense.

11. *Ambulance Depots.*—To be immediately available at all times, four-stretcher ambulances and passenger cars (sedans or station wagons) should be parked at hospitals, where drivers are always on duty, or else grouped in ambulance depots located at garages in various parts of the town. Only persons residing in or living in the vicinity of the hospitals or ambulance depots should be assigned as drivers of the vehicles.

12. *Interhospital Ambulance Units.*—An additional number of large vehicles such as busses should be promptly available day and night for the simultaneous exacuation of hospitals during an air raid. In heavy air raids it has been necessary to move as many patients from evacuated Casualty Receiving Hospitals to peripheral or Emergency Base Hospitals as from incidents to hospitals within the city. In exposed cities in the target zone, it should be possible to evacuate all patients from a hospital in two or at the most three hours without utilizing the ambulance transportation of the field casualty service.

Doctor Draft for Civilians Mapped

Government officials, on December 15th, brought forward a program for relieving the "doctor shortage" in distressed war areas and warned that physicians and dentists might have to be drafted and assigned to localities where the shortage is acute.

Meanwhile, Dr. Maxwell Lapham, executive officer of the Procurement and Assignment Service of the War Manpower Commission (WMC), announced that a plan has been agreed upon under which 11.455 doctors will be called into the armed services in 1943, leaving 80,000 physicians to take care of the home front.

One For Each 1,500

Doctor Lapham made the announcement at a public hearing by a Senate Education and Labor Subcommittee considering the manpower problem.

He explained that 80,000 physicians would effect a ratio of one for approximately every 1,500 persons. This, it was testified, is regarded as the outer limit of safety from the standpoint of public health.

Dr. Joseph Mountin, Assistant Surgeon General, told the subcommittee that doctors and dentists may have to be drafted and assigned to distressed war areas where the doctor ratio sometimes is one to 5,000. Doctor Lapham agreed that this step might have to be taken.

Both officials, however, favored a plan under which doctors, dentists and nurses would be employed by the United States Public Health Service and sent to war centers where the need is greatest.

Funds For Hiring

Doctor Mountin proposed that Congress start the program off by appropriating $5,000,000 to enable the Public Health Service to hire 1,000 physicians, dentists and nurses and place them where they would be most urgently needed. This program, he intimated, probably will have to be enlarged after it has been put into operation.

"I think it should be given a trial," he declared, "although the compulsory selection and redistribution of physicians may be needed eventually."

Earlier, Col. George Baehr, chief medical officer of Office of Civilian Defense (OCD), suggested to the subcommittee that physicians be "drafted" if necessary, for service in communities where a dangerous doctor shortage exists.

"In many areas," he said, "the ratio of physicians to the population has dropped below a safe level."

Proposes Method

Colonel Baehr proposed that some redistribution of physicians be carried out by State authorities or by the medical profession. If this cannot be done, he declared. "some Federal agency should have the responsibility of providing medical personnel so that the people in the community will not be left unprotected."

He said that recommendations by Federal medical authorities for allocation of critical materials to build hospitals to meet possible bombing raids or other war casualties had been turned down by the War Production Board (WPB).

Doctor Mountin testified that the Public Health Service had used its own funds to send a certain number of doctors and dentists to war areas where the need had become extreme. . . .

Civilian Medical Needs Being Met

While a critical shortage of doctors may prevail in some war plants and shipyards because of the abnormal influx of workers and military service calls, the average civilian medical situation is not yet acute and needs are being met, Dr. L. R. Chandler, dean of Stanford University School of Medicine, said at a recent conference.

Speaking on the medical manpower situation, Dr. Chandler stated 80 per cent of illnesses are of a minor nature, such as colds, smashed fingers or poison oak poisoning and can be handled adequately in doctors' offices. It is the other 20 per cent that concern physicians most, he said, because they may end in death or disability.

Dr. Chandler said adoption of continuous training programs by most medical schools will result in graduation of 21,000 physicians in the next three years instead of the usual 15,000 for the same period.

Asserts Half of Medical Practitioners to Serve in War

Dr. Dallas B. Phemister, Chairman of the department of surgery in the medical school of the Univer-

sity of Chicago, said in an address here recently that one-half of the active medical profession will be called into service when our fighting forces are doubled and more than 30,000 physicians are now required to treat the five million men in the armed forces.

Dr. Phemister said there are 150,000 actively practicing physicians in the United States, or one for each 850 persons. During the war the army requires one physician for every 166 soldiers and the navy requires one for every 154 sailors.

Highest Percentage of Doctors

"Our army has a higher percentage of physicians than that of any other country," Dr. Phemister said, "but we have a higher percentage of physicians than any other country. Russia has one physician for every 5,000 persons, while China has one for about every 50,000 persons.

"Physicians who remain in civil service have a heavier burden to bear, not only because of the enlistment of their colleagues, but to increased work in connection with war production, increased accidents among unskilled workers, and increases in occupational and infectious diseases. The government is planning to utilize some of the immigrant physicians for the care of war workers. No more commissions in the medical corps are being issued to them, which probably means that spies have been detected in their midst."

Diseases Vary with Locations

Dr. Phemister said that there was an average of seven cases of venereal disease per thousand men weekly and that its presence varied greatly with the location of the troops. . . .

OFFICE OF CIVILIAN DEFENSE
Washington, D. C.
(COPY)

Plasma for Civilian Defense

The Medical Division of the Office of Civilian Defense and the United States Public Health Service report the current status of the blood plasma program which was initiated in the early spring.

The report indicates that 130 hospitals have now received grants-in-aid and are preparing reserves of plasma to total at least 63,130 units. In addition to this reserve, 27,500 units of frozen plasma have been obtained through the Army and Navy from blood collected by the American Red Cross. This supply has been distributed. The Medical Division has also procured 37,500 units of dried plasma from blood collected by the American Red Cross, and this supply is in process of distribution.

The total reserve, which is largely concentrated in the 300 mile coastal target areas, will be 126,630 units for treatment of casualties resulting from enemy action. In addition, 1,250 units are in Puerto Rico and 250 in Alaska.

In addition to these sources of plasma, the Red Cross is distributing to target areas 5,000 units which will be available to the Office of Civilian Defense for treatment of civilian casualties resulting from enemy action. Many hospitals which have not received grants under the OCD-USPHS program are also preparing plasma reserves which total approximately 50,000 units.

Plasma required for the treatment of war-related injuries may be obtained by any community through its Chief of Emergency Medical Service. To meet such emergencies, plasma may be transferred: (1) within a State by the State Chief of Emergency Medical Service; (2) within a Region by the Regional Medical Officer; and (3) from one Region to another by the Medical Division, U. S. Office of Civilian Defense.

Courses for Gas Specialists

A new five-day gas specialist course for persons responsible for the organization of gas defense in the target areas will be presented in the six War Department Civilian Protection Schools conducted on behalf of and in collaboration with the U. S. Office of Civilian Defense, it was announced in Operations Letter No. 89, issued November 14. . . .

The first session of the gas specialists' course will be at Amherst College, Amherst, Massachusetts, November 29 through December 4. The course was offered December 13-18, inclusive, at the other War Department Civilian Protection Schools at Stanford University, Palo Alto, California, and Occidental College, Los Angeles. . . .

Presentation of the specialized course dealing with gas defense is part of a new plan of instruction in the War Department Civilian Protection Schools. The ten-day general course formerly given by the schools was discontinued with the session of November 1-11, and the new plan of specialized courses to be given in five days will be instituted. The other courses cover plant protection, basic civilian protection and instruction for staff members. . . .

Inasmuch as the Medical Division of the Office of Civilian Defense is responsible through its gas protection section for the administrative and technical organization of the gas program, responsibility for recruitment of students for the gas specialists' course was delegated to the Regional Medical Officers and the Regional Sanitary Engineers.

New Method of Administering Morphine

Because of the critical shortage of tin, the U. S. Office of Civilian Defense has been unable to procure syrettes for administration of morphine by physicians of Emergency Medical Service. To meet this serious difficulty, a new device using glass and plastic has been developed.

This device consists of a small, sealed-glass ampule containing ¼ gr. or ½ gr. of morphine in solution. This solution is under sufficient pressure to eject the entire contents. A piece of transparent plastic tubing encloses the neck of the ampule and connects it to the hub of the needle. The shaft of the needle is enclosed in a small glass tube, to which is attached a stylet. At the hub of the needle within the plastic tube is a small filter.

Following is the method of using the ampule:

1. The body of the ampule is grasped in the right hand.

2. The glass tube protecting the needle is withdrawn by a twisting and pulling movement of the fingers of the left hand.

3. With the needle pointing down and the body of the ampule vertical to the skin, the needle is inserted by jabbing it under the skin.

4. When the needle is in place, and with the ampule vertical to the skin, pressure is exerted with the thumb and two fingers on the plastic tubing to break the neck of the ampule. It is important that the ampule be held vertical to the skin, in order that morphine may not be lost by improper technique.

5. The pressure within the ampule ejects the contents. The filter prevents glass splinters from clogging the needle.

6. When the ampule is empty, the needle is withdrawn and the whole device is discarded.

First Aid Training No Longer Required for Staff Units in Citizens Defense Corps

Members of staff units of the U. S. Citizens Defense Corps are no longer required to acquire ten hours of

training in first aid, the U. S. Office of Civilian Defense has announced. It was pointed out that members of staff units would be employed in the headquarters of the Citizens Defense Corps rather than at the scene of air raid emergencies.

Air raid wardens, auxiliary police, auxiliary firemen, decontamination squads, messengers and members of the drivers corps are still required to have at least ten hours of first aid training. Nurses' Aides are required to take the regular first aid instruction in addition to their specified training given by the American Red Cross in connection with approved hospitals. The Medical Corps, a professional group, has special training as directed by the Medical Division of OCD.

Provision of Day Care for Children of Working Mothers

Committees or subcommittees charged with the provision of day care for the children of working mothers should be appointed by all State Defense Councils and by all local Defense councils in areas where day care is a problem, James M. Landis, Director of the U. S. Office of Civilian Defense, urged in Operations Letter No. 79, issued recently. It was pointed out that 5,000,000 women may be needed in industry by the end of 1943.

The State committee should be composed of representatives of the State departments of welfare, health, education, the U. S. Employment Service, the Works Projects Administration, organized labor, employers and other agencies and organizations concerned with child welfare in the State. The local committee should be composed of the local departments of health, welfare, education and health, the employment service, the Works Projects Administration, organized labor, employers, the local housing agency, and other agencies and organizations concerned with the welfare of children in the community.

State Defense Council committees should promote, coördinate and plan the State day-care program, the Operations Letter recommended. They should see that professional service is made available to local communities where day care is a problem, provide local committees with specific instructions and see that all resources—Federal, State and local—are focused on the problem in critical areas.

The task of the local committee is to bring to bear every available local resource, stimulating public and private agencies and organizations to take steps toward an adequate solution of the problem. It should find out the nature and extent of the need for day care; it should explore all possible types of care for children, and it should see that volunteers in child care are recruited, properly trained and effectively used.

Federal assistance for day care may be obtained from several sources. The Office of Defense Health and Welfare Services has funds which may be made available for State and local administrative and supervisory personnel in the field of day care. These funds will be allocated to State departments of welfare and education only after approval of a State plan by a committee of the State Defense Council. Funds may be obtained under the Lanham Act through the Federal Works Agency for operation and maintenance of day-care projects. Through allocation of funds for public schools, for instance, support may be obtained for nursery school projects. The State administrator of WPA can furnish information as to how to obtain Lanham Act funds for other types of projects. Finally, the Works Projects Administration has been authorized to spend $6,000,000 in 1942-1943 in the operation of day nurseries or nursery schools for children of employed mothers.

The Operations Letter concludes with instructions to Regional Offices of Civilian Defense to look into the day care problem in their Regions immediately, reviewing the extent and efficiency of the existing committees, distributing informative literature and seeking out particular problems such as lack of facilities and funds, lack of coöperation among agencies and any other matters that may be impeding the program.

Federal Financing of Transportation to Emergency Base Hospitals

Federal financing of transportation necessary in evacuating casualties and other hospitalized sick to Emergency Base Hospitals can be accomplished only through State evacuation authorities, Dr. George Baehr, Chief Medical Officer of the Office of Civilian Defense, points out in a circular (Medical Series No. 22), prepared for officials of the Emergency Medical Service. . . .

New Bulletin on Sanitation

Maintenance of sewer service in bombed areas has been one of the major difficulties confronting municipal authorities in cities under enemy attack. To assist American municipal officials and defense councils in planning for emergencies and for the restoration of normal service following damage resulting from enemy action, the sanitary engineering section of the Medical Division of the Office of Civilian Defense has issued its second sanitary engineering bulletin, "Municipal Sanitation Under War Conditions." . . .

Civilian Defense Plans for Mortuary Service

The Medical Division of the Office of Civilian Defense has issued "Medical Division Bulletin No. 5, Emergency Mortuary Services," presenting plans for the organization of this essential part of the casualty services.

The bulletin suggests that the local Chief of Emergency Medical Service work in coöperation with the medical examiner or coroner, the chief of police, the health officer and representatives of the private funeral directors and cemeteries. . . .

Military Clippings—Some news items of a military nature from the daily press follow:

McNutt Outlines America's Manpower Program for 1943

Addition of 2,500,000 Workers to Bring Over-all Total to 62,500,000 at War Tasks Held Necessary

By Paul V. McNutt, War Manpower Commission Chairman

(Written for the United Press)

Washington, Dec. 28.—Two manpower tasks face the United States in 1943:

First, the replacement of men being drawn in ever-increasing numbers into the armed forces. The second is the addition of more than 2,500,000 workers which will bring the total force to an all-time high of 62,500,000 workers, including the armed forces.

To meet these objectives, millions must go to work who never before entered the labor market.

What to Expect

A few of the developments to be expected in the coming months may be summed up as follows:

1. New millions of women will be added to the working force.

2. Industry will add to its rolls millions who five years ago it might have rejected for a variety of reasons such as age, sex, color, or minor physical handicaps.

3. There will be an acceleration of industrial training programs designed to facilitate the use of new and heretofore inexperienced workers.

Protect Rights

4. Labor and management in hundreds of communities and industries will work out plans for controlling hiring practices and channeling the right workers to the right war jobs.

5. These agreements will include provisions for protecting reëmployment rights and seniority rights in order

to stimulate the transfer of workers from civilian industries to war work.—Los Angeles *Times*, December 29.

* * *

Navy Hospital Commissioned

New Institution Located on Bixby Rancho, Near Long Beach, California

"For those who have borne the brunt of battle," the Navy's new $3,000,000 hospital on 89 acres of the old Bixby Rancho, near Long Beach, California, was commissioned yesterday, by Capt. Schuyler F. Heim, commanding officer of the San Pedro Naval Operating Base.

Today the first of the institution's patients will be transferred from outlying hospitals.

Erected in 14 months, the hospital is said to be the finest structure of its kind in America.

"The Secretary of the Navy has delegated to me the honorable duty of placing this new naval hospital in commission," Capt. Heim said in his dedicatory speech.

"Here we have erected a haven of solace, refuge and recovery for those who have borne the brunt of battle."

The hospital now contains 300 beds, but under future plans it will be outfitted with accommodations for 1200 patients.

In command of the institution is Capt. W. Howard Michael of the Navy Medical Corps. His service during the Pearl Harbor attack earned Capt. Michael the Navy Cross and the Army's Distinguished Service Cross.—Los Angeles *Times*, December 16.

* * *

1943 Draft to Call Up More Than 3,500,000

18-19 Age Group Will Furnish Half of Men Slated for Induction During New Year

Washington, Dec. 27.—(AP.)—The New Year will bring calls to the colors for more than 3,500,000 men 18 through 37 years old, Selective Service sources estimated today, at the average rate of 250,000 to 300,000 a month.

The 18 and 19 year olds completing their registration this month will comprise perhaps half of these inductees. If the ratio maintains, then the other 1,750,000, more or less, will be childless married men, for the pool of single men 20 to 38 years old available for military service has been virtually exhausted.

Big Call Coming

The armed forces will have to attain their planned strength of 9,700,000 men below officer rank by the end of next year almost exclusively from 21,000,000 to 22,000,000 men in the 18 through 37 year bracket, and that bracket has been tapped for most of the 6,100,000 or more men now in the ranks. A strength in ranks of 7,500,000 for the Army, 1,500,000 for the Navy, 400,000 for the Marines and 300,000 for the Coast Guard is planned by January 1, 1944.

Starting next month, as a general rule, draft boards will begin calling up an accumulated pool of some 600,000 to 900,000 men now 18 or 19 years old, and each month thereafter about 100,000 more will pass their eighteenth birthdays and be subject to classification for service.

Figures Withheld

Although some of these youths will be deferred for occupation, or dependents, or as college students specializing in medical and scientific work, their availability will more than offset the addtional calls made upon men 20 through 37 by the blanket deferment of men 38 or older.

Figures showing the percentage of inductees by age groups have been withheld as a military secret since Pearl Harbor, but it is obvious that comparatively few 38 through 45 year olds had been taken despite lowering of Army physical requirements since then. Older men not only have less physical capacity, but also more claims to deferment. In the twelve months before the United States entered the war, when the top draft induction age was 35, there were only 9,821 men of 35 and 12,322 of 34 among the first 921,000 inducted.

200,000 Married Men

Exact figures on the number of childless married men to be called next year also have been kept secret, but estimates advanced during Congressional debate were that as many as 200,000 would be among this month's inductees.

Of the 17,388,000 registered under the draft at Pearl Harbor time, 10,160,000 held deferment on grounds of dependency and less than 600,000 were deferred for occupational reasons. Since then, more weight has been given to occupation and less to dependency.

Passage of legislation providing funds to dependents of service men did much to lessen dependency deferments, while executive action and legislation to insure essential industry and agriculture against disruptive drains on manpower strengthened occupational deferments.—San Francisco *Examiner*, December 28.

* * *

Death Rate of Wounded Low in Solomons

Washington, Dec. 15.—(UP.)—Rear Admiral William Chambers of the Navy Medical Corps, just returned from the South Pacific, reported today that the mortality rate among wounded evacuated from the Solomons to mobile hospitals remains below the normal expectancy.

He said the major share of credit for this situation was due to speedy evacuation of the wounded to fully staffed, well-equipped hospitals, sulfa drugs, blood plasma, tetanus toxoid and efficient doctors and hospital corps men.

Rear Admiral Ross T. McIntyre, Navy Surgeon General, reported last month that the mortality rate among wounded evacuated from the Solomons was only 1 per cent for the first 1000 men. This compared with a normal expectancy of at least 5 per cent.

Chambers did not cite statistics but he indicated that this favorable showing is continuing.

"From a medical standpoint, the situation is definitely encouraging," he said.—San Francisco *Chronicle*, December 16.

* * *

Hospitals on Front Lines Prove Value

Portable Units Show Worth in New Guinea Jungle

With American Forces in New Guinea, Dec. 22 (Delayed).—A Boston surgeon, handling his instruments as deftly as if he were still working in the Massachusetts General Hospital, saved the life of an American soldier today in a portable field hospital, hidden in the jungle a few miles from the firing line.

The surgeon was Major George Marks. His operating table was a canvas stretcher mounted on empty wooden ration boxes. His nurse was a shirtless enlisted man, who handed him instruments sterilized in water boiled over an open fire.

While Major Marks worked fast, opening the soldier's abdomen, clamping and sewing his ruptured intestines, Lieutenant Frederick Ross of Boston kept him strengthened with transfusions of plasma. The operation was performed with spinal anesthetic.

Major Marks said the badly wounded soldier arrived at the hospital three hours after a Japanese sharpshooter had hit him. If the hospital had been as far back as was usual in the last war, he probably would have died.

Captain James D. Campbell of Boston, formerly of Chicago, assisted by Lieutenant John Lambert of New York, who was trained in Boston, recently performed a delicate brain operation successfully at the same hospital.

"We requested this duty," Captain Campbell said. "We are most pleased with the Army's new portable hospitals. Doctors can do much more for wounded men when they are able to operate promptly, and the best way is to be as close as possible to the front lines."—San Francisco *News*, December 28.

* * *

'Deferment Policy Shaping'

Washington, Dec. 11.—(UP.)—President Roosevelt today appointed a special three-man committee to formulate uniform policies governing occupational deferment of Federal employees from the draft.

Mr. Roosevelt left reporters with the impression that the committee's policies might develop also into an overall guide for occupational deferments in private industry....

The President said the special committee was directed to give consideration to standards for determining:

1. Whether an employee is actually performing duties which are critically essential to the war effort.
2. Whether the employee can be replaced by others who are not eligible for military service.
3. Whether the employee's skills and abilities can best be used to make his maximum contribution to the total war effort in his civilian assignment or in military service. . . .—San Francisco *News*, December 11.

* * *

There's No Need to Be a Neurotic Nellie

A congressman from New Jersey recently called up the headquarters of the government agency charged with recruiting doctors for the armed services, moaning low that a lot of the people in a town of this congressman's district were protesting that one of the doctors of this community was about to be commissioned in the navy medical corps.

The congressman's constituents, needless to say, wanted something done about it. They wanted their doctor released from having to go in the navy. If something

wasn't done about it, the town was proposing to organize a delegation of 40 people to come down to Washington and get action. It was that serious. War or no war, these people weren't going to let the nasty old Navy take their beloved doctor away from them. War or no war, 40 people were going to put a further strain on the eastern railroads' transportation jam by traveling to Washington on a perfectly unnecessary journey.

A check-up on this particular situation back in Jersey revealed these facts:

The doctor in question was and had been for some time a commissioned officer in the Naval Reserve Medical Corps. He was not only willing but anxious to get into service. He was not the community's only physician. There would be no shortage of competent medical talent in the community.

And though this doctor couldn't exactly protest to his patients because of their devotion to him, his medical career in service was about to be ruined by the selfishness of a group of silly people who didn't want any other doctor to move into the community because they were afraid that after the war was over their old doctor might not come back.

Gave It Up

In the end, the delegation of 40 was persuaded not to come to Washington, and it looks as though the popular young doctor will go into service whether his patients want him to or not.

This situation is dealt with in this detail and in more space than it is probably worth because it is typical of a lot of the squawks that come into the headquarters of the Procurement and Assignment Service of the War Manpower Commission, which has the job of mobilizing the country's medical strength for war.

It is really amazing how much hell one neurotic Nellie can raise when she starts out to make a nuisance of herself, but the fact is that when a lot of the doctor-shortage scares are investigated they can be traced down to the individual head and bellyaches of people who think there is only one doctor in the world for their case.

How much choice do you suppose the soldier or sailor with half a leg or an arm shot off has in the selection of the surgeon who attends him? The answer is that he's glad to get whatever sawbones or pill dispenser happens along. . . . And as for Army medication, it has long survived on a reputation for administering shots, iodine or salts for all ailments, so if the armed services can survive on such treatment, civilians should be able to get along.

Stretch It Out

All this is not set down to minimize the fact that there are genuine shortages of doctors in some areas, and that these shortages may be caused by heavy recruitment of physicians. You can't slap 50,000 or 150,000 workers into a new war production area that two years ago was a great open space and expect them to get along without doctors.

But the answer is that civilian medical practice will have to be stretched farther. Specialists will have to give up their exclusive fields and become just plain old-fashioned family doctors. And patients will have to learn to adjust their illnesses.

Quit getting the doctor out in the middle of the night. You call at his office instead of making him call at your bed of pain.

There are so many sides to this question of the doctor shortage, however, that the subject will have to run into two more installments.—Visalia *Times-Delta*, December 2.

* * *

Take Cold or Bruise to Doctor; Don't Call Him to Your Home

Palo Alto.—(AP.)—"The hours of every civilian doctor are budgeted," Dr. L. R. Chandler of Stanford University said yesterday, and "patients suffering from poison oak will just have to wait for the patient who has coronary occlusion."

Dr. Chandler's comment was made in a review of civilian medical needs at a time when the armed forces are increasing their demand on the services of physicians and surgeons.

Speaking at a luncheon meeting of the Stanford Associates, the dean of the university's medical school said that although a critical shortage of doctors existed in some areas crowded by abnormal concentrations of war workers, for the most part civilians still are receiving all necessary medical care.

In time, Dr. Chandler pointed out, the present program of accelerated training adopted by most of the country's medical schools will bring results in the graduation of 50 per cent more qualified practitioners each year.

Until then, he suggested, the situation could be kept in hand if civilians would make a point of taking their minor afflictions, such as colds or smashed fingers, to doctor's offices for treatment. Eighty per cent of the cases on which physicians are called are of this secondary nature, he estimated.—Sacramento *Union*, December 9.

* * *

Misfits Are New Menace to Country

Chicago, Dec. 5.—(UP.)—Capt. David J. Flicker, M. D., said today that "tens of thousands" of Army inductees mentally and nervously unfit for service are being taken into the Army because of insufficient time allowed medical interviewers at induction boards.

Flicker, writing in *War Medicine*, published by the American Medical Association, estimated that 5 to 10 per cent of draft age men have psychiatric disorders which would cause them to break down under military life. Once these men become psychiatric war casualties, he said, the country must spend millions of dollars for their hospitalization and compensation.

At his post, Camp Blanding, Fla., one of the country's most active induction centers, Flicker said psychiatrists have only two or three minute interviews with inductees and no individual medical histories to detect these disorders.

To correct the situation, Flicker suggested: obtaining psychiatric histories from local selective service boards, schools and social service agencies, allowing a minimum of five minutes per interview and obtaining assistance from psychiatrists at State hospitals and institutions.—Hanford *Journal*, December 6.

COMMITTEE ON SCIENTIFIC WORK

OFFICIAL NOTICES: ANNUAL SESSION

Decision to hold a two-day, streamlined Annual Session of the California Medical Association in Los Angeles, Sunday, May 2nd—Monday, May 3rd, 1943, received comment in the December issue of CALIFORNIA AND WESTERN MEDICINE, on page 341.

Because of existing difficulties regarding transportation and to reassure members concerning rail and air schedules to Los Angeles, the information noted below is appended.

As stated in CALIFORNIA AND WESTERN MEDICINE, in December, the headquarters will be at Hotel Biltmore on Olive, between Fifth and Sixth Streets. Preliminary information concerning hotels appears below. In due course, other announcements will be made.

Members of the Association who have scientific papers in mind should promptly communicate with the proper Section Secretary. The list of Section Officers appears in each issue of CALIFORNIA AND WESTERN MEDICINE, on advertising page 6.

* * *

Transportation Information

Following schedules are subject to change.

Southern Pacific

SAN FRANCISCO

Name of Train	*Number*	*Leave San Francisco*	*Arrive Los Angeles*
		Coast Route	
Morning Daylight	98	8:15 a. m.	6:00 p. m.
Coaster	70	6:30 p. m.	8:30 a. m.
Lark	76	9:00 p. m.	9:00 a. m.
		Valley Route	
Owl	26	6:00 p. m.	8:35 a. m.
San Joaquin Daylight	52	7:30 a. m.	8:00 p. m.

OAKLAND

		Leave Oakland	Arrive Los Angeles
Owl	26	6:32 p. m.	8:35 a. m.
Lark	74-76	8:00 p. m.	9:00 a. m.

SACRAMENTO

		Leave Sacramento	Arrive Los Angeles
West Coast	15-60	8:00 p. m.	9:10 a. m.

* * *

United Airlines

United Airlines at the present time has a schedule showing nine flights daily between San Francisco and Los Angeles.

Hours of departure from San Francisco are as follows: 3:05 a.m., 6:45 a.m., 8:30 a.m., 11:00 a.m., 2:00 p.m., 4:00 p.m., 4:45 p.m., 6:15 p.m., and 8:30 p.m.

Hours of arrival in Los Angeles of the above airships are: 5:46 a.m., 9:15 a.m., 10:30 a.m., 1:38 p.m., 4:00 p.m., 6:10 p.m., 7:26 p.m., 8:25 p.m., and 10:40 p.m.

Los Angeles departure schedule to San Francisco follows: 7:00 a.m., 9:00 a.m., 11:00 a.m., 12:45 p.m., 2:15 p.m., 5:00 p.m., 6:45 p.m., 8:00 p.m., and 11:30 p.m.

The round trip fare between San Francisco and Los Angeles is $37.90—one way $18.95.

Reservations should be made in ample time. The San Francisco office of United Airlines is 400 Post Street.

United Airlines also flies airships between Los Angeles and San Diego, the round trip being $12.00—one way $6.00.

* * *

Santa Fe Railroad

San Francisco The Santa Fe at the present time has a schedule of 9 trains daily between San Francisco-Oakland and Los Angeles. (All San Francisco trains transfer to bus, at Bakersfield.)

Hours of departure from San Francisco are as follows: 9:00 a.m. (Streamliner), 3:00 p.m., 6:00 p.m. (Streamliner), and 11:30 p.m.

Hours of arrival in Los Angeles of the above trains are: 7:05 p.m., 4:10 a.m., 4:10 a.m., and 1:20 p.m.

San Diego The Santa Fe has 5 trains and 11 buses between Los Angeles and San Diego daily, the round trip being $3.03 by either train or bus, one way by bus $1.98 and by train $2.18.

Hotels: Los Angeles

The official headquarters of the next Annual Session will be the Biltmore Hotel, Los Angeles. Owing to existing conditions, it is probable that the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, the date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

LOS ANGELES HOTELS: WITH TELEPHONE NUMBERS

A list of some hotels in Los Angeles within easy distance of the Biltmore.

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
*Biltmore Hotel**, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 529 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 615 S. Alexandria Ave.	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 830 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave.	(MIchigan 1331)
Monarch Hotel, 905 W. Fifth St.	(MIchigan 7311)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	(EXposition 3181)

* Headquarters Hotel.

* * *

BILTMORE HOTEL: HEADQUARTERS HOTEL

515 S. Olive (MIchigan 1011)

Mr. Alvin Knocke, Assistant Manager
(In charge of reservations)

Single rooms	$5.00, $5.50, $6.00, $6.50 and $7.00
Double rooms	$7.00, $7.50, $8.00, $8.50 and $9.00
Suites	$12.00, $15.00, $20.00

All rooms in the Biltmore have individual private baths, and in the case of the doubles, twin or double beds are optional.

AMBASSADOR HOTEL

3400 Wilshire Blvd. (DRexel 7011)

Mr. J. E. Benton, Manager

Single room with bath, one person	$ 5.00
Double room with bath, two persons	8.00
Twin beds	15.00
Two single rooms, bath between, two persons, each	8.00
Two double rooms, bath between, four persons, each	15.00

ALEXANDRIA HOTEL

210 W. Fifth St. (MAdison 2741)

Mr. Clayton V. Smith, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

CHAPMAN PARK HOTEL

615 S. Alexandria Ave. (FItzroy 1181)

Mr. Harry S. Ward, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

CLARK HOTEL

426 S. Hill St. (MIchigan 4121)

Mr. Beckett, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

GATES HOTEL

830 W. Sixth St. (TRinity 3931)

Mr. Vernon Peck, Manager

Single room without bath, one person	$1.50
Double room without bath, two persons, each	1.50
Single room with bath, one person	3.00
Double room with bath, two persons	4.00
Two single rooms, bath between, two persons, each	4.00
Two double rooms, bath between, four persons, each	4.00

HAYWARD HOTEL

206 W. Sixth St. (MIchigan 5151)

Mr. Russell Wagner, Manager

Single room without bath, one person	$2.00
Double room without bath, two persons, each	2.50
Single room with bath, one person	2.50
Double room with bath, two persons	3.00
Two single rooms, bath between, two persons, each	3.50

MAYFAIR HOTEL

1256 W. Seventh St. (FItzroy 4161)

Mr. H. H. Hasslinger, Manager

Single room with bath, one person	$2.75
Double room with bath, two persons	3.30

MAYFLOWER HOTEL

535 S. Grand Ave. (MIchigan 1331)

Mr. J. B. Huesman, Manager

Single room with bath, one person.....$2.75
Double room with bath, two persons..... 3.85
Connecting rooms with bath..... 3.80

ROSSLYN HOTELS

111 W. Fifth St. (MIchigan 3311)

Mr. E. S. Heckler, Manager

Single room without bath, one person.....$1.50
Double room without bath, two persons..... 2.00
Single room with bath, one person..... 2.00
Double room with bath, two persons..... 3.00

WILLIAM PENN HOTEL

2208 W. Eighth St. (EXposition 3181)

Mrs. Dawn Olson, Manager

Single room with bath, one person.....$2.00
Double room with bath, two persons..... 2.50
With twin beds..... 3.50

TOWN HOUSE HOTEL

639 S. Commonwealth Ave. (EXposition 1234)

Mr. C. W. Gaskell, Manager

Single room with bath, one person.....$ 6.00
Double room with bath, two persons..... 7.00
Single suites with baths..... 10.00

HOTEL STILLWELL

838 S. Grand Ave. (TRinity 1151)

Mr. F. W. Morris, Manager

Single room with bath, one person.....$3.50
Double room with bath, two persons..... 4.00

SAVOY HOTEL

601 W. Sixth St. (MAdison 1411)

Mrs. Leslie Consolloy, Manager

Single room without bath, one person.....$2.00
Double room without bath, two persons..... 2.75
Single room with bath, one person..... 2.75 up
Double room with bath, two persons..... 2.75 up

CARLTON HOTEL

529 S. Figueroa St. (MIchigan 6571)

Mr. Tom Miles, Manager

Single room with bath, one person.....$2.00
Double room with bath, two persons..... 3.00
Two double rooms, bath between, per suite..... 5.00

MONARCH HOTEL

905 W. Fifth St. (MIchigan 7311)

Mr. J. Westerbach, Manager

Single room with bath, one person.....$2.00
Double room with bath, two persons..... 3.00

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Basic Science Act — Proposition No. 3 on the November 3, 1942, Ballot. Final Figures

As a matter of final record, CALIFORNIA AND WESTERN MEDICINE is reprinting from Publication 19012 of the State of California on "Statement of Vote of the General Election of November 3, 1942," the final and official figures by counties.

It will be noted therefrom that with the exception of three counties, the measure went down to defeat, the total vote for the Basic Science Act being 584,324 and the total ballot against the proposed law being 1,132,957.

The three counties which cast more votes in favor than against were Marin (124), San Mateo (80), and San Francisco (16,770). The figures in brackets show the favorable majority in these three counties.

Detailed vote follows:

Counties	*Yes Votes*	*No Votes*
Alameda	68,160	84,638
Alpine	17	62
Amador	433	1,167
Butte	2,752	5,727
Calaveras	551	1,242
Colusa	597	1,433
Contra Costa	11,053	18,117
Del Norte	317	530
El Dorado	656	2,257
Fresno	8,526	25,652
Glenn	957	2,023
Humboldt	4,264	6,950
Imperial	1,643	3,886
Inyo	502	1,130
Kern	7,435	16,392
Kings	1,502	4,383
Lake	511	1,387
Lassen	748	1,785
Los Angeles	218,517	539,971
Madera	847	2,777
Marin	6,278	6,154
Mariposa	319	771
Mendocino	1,552	3,728
Merced	2,334	5,046
Modoc	301	920
Mono	80	274
Monterey	5,081	7,644
Napa	3,219	3,465
Nevada	1,266	2,354
Orange	9,820	27,259
Placer	1,597	4,639
Plumas	506	1,275
Riverside	6,691	16,697
Sacramento	11,108	29,942
San Benito	1,209	1,129
San Bernardino	8,957	26,541
San Diego	22,212	42,704
San Francisco	89,027	72,257
San Joaquin	6,021	19,891
San Luis Obispo	2,872	5,212
San Mateo	14,881	15,197
Santa Barbara	5,426	11,428
Santa Clara	17,935	26,601
Santa Cruz	4,404	7,035
Shasta	1,401	3,915
Sierra	140	371
Siskiyou	1,915	3,707
Solano	4,325	7,927
Sonoma	5,774	10,895
Stanislaus	4,274	11,458
Sutter	666	2,887
Tehama	779	2,329
Trinity	282	590
Tulare	4,292	11,962
Tuolumne	850	1,716
Ventura	3,723	9,497
Yolo	2,264	3,460
Yuba	555	2,566
Totals on No. 3 (Basic Science)	584,324 (Yes)	1,132,957 (No)

California Legislature to Streamline New Session

Lyon, Slated for Speakership of Assembly, Reveals Plan to Speed Up Work in 1943

Sacramento, Dec. 14.—(AP.)—Further streamlining of legislative procedure is in prospect for the fifty-fifth session, Assemblyman Charles Lyon said today in support of a prediction that the legislature may finish its work by late April or May.

The veteran Los Angeles Assemblyman, who appears to be slated for the speakership, said that a forty-day constitutional recess, instead of the usual thirty days, probably will be taken to enable the State printing plant to turn out the bills introduced at the opening session despite the reduction of its force by war demands. . . .

The plan to facilitate proceeding will include the convening of assembly sessions at 10 a. m. instead of 2 p. m., reduction of standing committees from fifty-seven to twenty-seven, with no members holding membership on more than four committees, a simplification of House rules and the holding of committee meetings from 3 p. m. to 6 p. m., and at nights instead of in the forenoon. . . . —San Francisco *Examiner*, December 15.

CALIFORNIA LEGISLATURE: 55TH SESSION

Roster of State Senators and State Assemblymen

Much legislation related to public health work will be submitted to the Legislature now in session at Sacramento. For the convenience of C.M.A. members the Senate and Assembly rosters appear below. Addresses given are home addresses. At Sacramento, the legislators may be addressed in care of Senate or Assembly Chamber, the Capitol, Sacramento.

State Senators

(Senators from odd-numbered districts were elected in 1940)

District Number

1 Harold J. Powers (R)—Eagleville
2 Randolph Collier (R)—555 North Main Street, Yreka
3 Irwin T. Quinn (D)—First National Bank Building, Eureka
4 George Milton Biggar (R)—Covelo
5 Oliver J. Carter (D)—Carter Building, Redding
6 Charles H. Deuel (D)—273 East Sacramento Avenue, Chico
7 Jerrold L. Seawell (R)—303 Mariposa Avenue, Roseville
8 Clair Engle (D)—1010 Jackson Street, Red Bluff
9 H. E. Dillinger (D)—618 Main Street, Placerville
10 W. P. Rich (R)—Marysville
11 Frank L. Gordon (R)—Suisun
12 Herbert W. Slater (D)—800 Fourth Street, Santa Rosa
13 Thomas F. Keating (D)—Freitas Building, San Rafael
14 John F. Shelley (D)—69 Beachmont Drive, San Francisco
15 Thomas McCormack (R)—Rio Vista
16 Arthur H. Breed, Jr. (R)—315 Fifteenth Street, Oakland
17 T. H. DeLap (R)—American Trust Building, Richmond
18 Byrl R. Salsman (R)—2030 Webster Street, Palo Alto
19 John Harold Swan (D)—1133 Marian Way, Sacramento
20 Bradford S. Crittenden (R)—145 East Harding Way, Stockton
21 Harry L. Parkman (R)—934 Rosewood Drive, San Mateo
22 Hugh P. Donnelly (D)—953 Sierra Drive, Turlock
23 H. R. Judah (R)—42 Third Street, Santa Cruz
24 George J. Hatfield (R)—P. O. Box C., Newman
25 Edward H. Tickle (R)—Carmel
26 Jesse M. Mayo (R)—Angels Camp
27 R. R. Cunningham (D)—Hanford
28 Charles Brown (D)—Shoshone
29 Chris N. Jespersen (R)—Atascadero
30 Hugh M. Burns (D)—3307 Huntington Boulevard, Fresno
31 Clarence C. Ward (R)—220 La Arcada Building, Santa Barbara
32 Frank W. Mixter (R)—303 East Palm Street, Exeter
33 James J. McBride (D)—471 East Main Street, Ventura
34 Jesse R. Dorsey (R)—1028 Q Street, Bakersfield
35 Thomas H. Kuchel (R)—Bank of America Building, Anaheim
36 Ralph E. Swing (R)—Central Building, San Bernardino
37 Vacancy—Riverside County
38 Jack B. Tenney (D)—3201 West Seventy-second Street, Los Angeles
39 E. George Luckey (D)—307 West Eighth Street, Brawley
40 Ed Fletcher (R)—869 Rosecrans Boulevard, San Diego

(R) *Republican Senators* 23
(D) *Democratic Senators* 16
Vacancy 1
40

State Assemblymen

District Number

1 Michael J. Burns (R)—1644 Summer Street, Eureka
2 Paul Denny (R)—Etna
3 Lloyd W. Lowrey (D)—Rumsey
4 Albert M. King (D)—Riverside Drive, Oroville
5 Ernest C. Crowley (D)—Fairfield
6 Allen G. Thurman (R)—Colfax
7 Richard H. McCollister (R)—77 Marguerite Avenue, Mill Valley
8 Chester F. Gannon (R)—3543 H Street, Sacramento
9 Earl D. Desmond (D)—2022 Twenty-second Street, Sacramento
10 Harold F. Sawallish (D)—American Trust Building, Richmond
11 Charles M. Weber (R)—219 North Sutter Street, Stockton
12 James E. Thorp (R)—Lockeford
13 Francis Dunn, Jr. (D)—1634 Sixty-ninth Avenue, Oakland
14 Randal F. Dickey (R)—3221 Thompson Avenue, Alameda
15 Bernard A. Sheridan (R)—3135 Sheffield Avenue, Oakland
16 Arthur W. Carlson (R)—12 Marlborough Court, Piedmont
17 Edward J. Carey (R)—4506A San Pablo Avenue, Emeryville
18 Gardiner Johnson (R)—765 San Luis Road, Berkeley
19 Bernard R. Brady (D)—886 Thirty-ninth Avenue, San Francisco
20 Thomas A. Maloney (R)—350 Missouri Street, San Francisco
21 Albert C. Wollenberg (R)—2748 Steiner Street, San Francisco
22 George D. Collins, Jr. (D)—1456 Union Street, San Francisco
23 William Clifton Berry (D)—3747 Twentieth Street, San Francisco
24 Edward F. O'Day (D)—1353 Church Street, San Francisco
25 Gerald P. Haggerty (D)—155 St. Elmo Way, San Francisco
26 Edward M. Gaffney (D)—2081 Fifteenth Street, San Francisco
27 Harrison W. Call (R)—Eaton Drive, Redwood City
28 Raup Miller (R)—2237 El Camino Real, Palo Alto
29 John F. Thompson (D)—Route 4, Box 299, San Jose
30 Ralph M. Brown (D)—915 Carolyn Avenue, Modesto
31 George A. Clarke (R)—Route 1, Box 105, Le Grand

32 Jacob M. Leonard (R)—470 Hawkins Street, Hollister
33 Fred Weybret (R)—Star Route, Soledad
34 J. G. Crichton (D)—752 Buckingham Way, Fresno
35 S. L. Heisinger (D)—Route 4, Box 90E, Fresno
36 C. L. Guthrie (D)—627 Mill Street, Porterville
37 Alfred W. Robertson (D)—1524 Garden Street, Santa Barbara
38 Walter J. Fourt (R)—315 Lupin Way, Ventura
39 Thomas Harold Werdel (R)—2200 Pine Street, Bakersfield
40 William H. Rosenthal (D)—409 South Boyle Avenue, Los Angeles
41 Julian Beck (D)—423 Hagar Street, San Fernando
42 Everett G. Burkhalter (D) — 11005 Morrison Street, North Hollywood
43 C. Don Field (R)—1552 Ridgeway Drive, Glendale
44 John B. Pelletier (D)—248 South Olive Street, Los Angeles
45 Thomas J. Doyle (D)—4333 Griffin Avenue, Los Angeles.
46 Glenn M. Anderson (D)—582 North Hawthorne Boulevard, Hawthorne
47 Willis Sargent (R)—300 Bellfontaine, Pasadena
48 T. Fenton Knight (R)—4850 Oakwood Avenue, La Canada
49 Lee T. Bashore (R)—250 Live Oak, Glendora
50 Thomas M. Erwin (R)—1425 South Central Avenue, El Monte
51 Elwyn S. Bennett (D)—918 South Fraser Avenue, Los Angeles
52 Jonathan J. Hollibaugh (R)—6908 Rugby Avenue, Huntington Park
53 Lothrop Smith (R)—568 North Milton Drive, San Gabriel
54 John B. Knight (R)—5224 Maywood, Eagle Rock
55 Vernon Kilpatrick (D)—1246 South Hope Street, Los Angeles
56 Ernest E. Debs (D)—2324 Teviot Street, Los Angeles
57 Franklin J. Potter (R)—3277 Primera Avenue, Hollywood
58 Frank J. Waters (R)—959 Keniston Avenue, Los Angeles
59 Charles W. Lyon (R)—604 North Oakhurst Drive, Beverly Hills
60 Jesse Randolph Kellems (R)—454 Cuesta Way, Bel Air, Los Angeles
61 Lester A. McMillan (D)—2726 Forrester Drive, Los Angeles
62 Augustus F. Hawkins (D)—220 East 46th Street, Los Angeles
63 Don A. Allen (D)—3867 Degnan Boulevard, Los Angeles
64 John C. Lyons (R)—3208 Bellevue Avenue, Los Angeles
65 John W. Evans (D)—4813 South Western Avenue, Los Angeles
66 Jack Massion (D) — 846 East Seventy-seventh Street, Los Angeles
67 Clayton A. Dills (D)—15145 South Vermont Avenue, Gardena
68 Vincent Thomas (D)—722 West Twentieth Street, San Pedro
69 Ralph C. Dills (D)—1505 North Spring Street, Compton
70 Lorne D. Middough (D)—233 Roswell Avenue, Long Beach
71 Fred N. Howser (R)—3940 Linden Avenue, Long Beach
72 R. Fred Price (R)—303 West Emporia Avenue, Ontario
73 Douglas P. Armstrong (R) — Palmetto Street, Redlands
74 Clyde A. Watson (R) — 273 North Harwood Street, Orange
75 Sam L. Collins (R)—North Cypress Avenue, Fullerton
76 Nelson S. Dilworth (R)—Route 1, Box 18, Hemet
77 Harvey E. Hastain (R)—277 West K Street, Brawley
78 Frederick H. Kraft (R)—1889 Bacon Street, San Diego
79 Kathryn T. Niehouse (R)—4889 Bancroft Street, San Diego
80 Charles W. Stream (R)—664 Del Mar Avenue, Chula Vista

(R) *Republican Assemblymen 44*
(D) *Democratic Assemblymen 36*

80

CALIFORNIA'S MEDICAL PRACTICE ACT—ARE TEMPORARY LICENSES TO PRACTICE DESIRABLE?

The items which appear below are referred to in brief editorial comments which appear on page 2. ("Item A draft" was submitted by the American Federation of Medical Boards.)

Item A

A draft of proposed legislation to authorize and provide for the temporary admission to practice in the States of physicians and dentists to protect the health of the civilian population during the war emergency period.

Be it enacted . . .

Section 1. *Purpose.* A serious public emergency exists or may exist in this State because of the demands of the armed services for physicians and dentists. Coöperation on the part of the State, with certain Federal agencies, such as the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians of the War Manpower Commission is imperative, so that temporary relocation of physicians and dentists may be accomplished, to overcome acute shortages in specific localities from time to time. For the protection of the health and welfare of the people of the State, power to provide for the temporary admission to practice in the State of physicians and dentists, licensed as such outside the State, is hereby conferred upon the State Board of Medical Registration and Education* and the State Board of Dental Registration and Education* upon conditions and under regulations prescribed by them.

Section 2. *Power to provide for the temporary admission to practice medicine and dentistry in the State.* To accomplish the purpose set forth in Section 1, and notwithstanding any inconsistent provision of law, the State Boards of Registration and Education in Medicine and Dentistry* shall have power by general regulations or specific orders, to issue temporary emergency certificates to such physicians and dentists, licensed as such outside the State, as they shall find qualified to practice as such in the State during such emergency. The holder of any such temporary certificate shall be privileged during the term specified therein, unless sooner revoked, to practice his profession within the State, subject however, to all laws of the State generally applicable to the practice of such profession and to such regulations, restrictions, and area limitations as the State Boards* may make or impose as to them or any of them and their practice within the State.

* Substitute appropriate licensing agency or group existing in your State.

Item B

Statement of Principles to be recommended to the respective State Boards of Registration and Education in Medicine and Dentistry.

1. The need for relocation or assignment of physicians or dentists shall be determined by the Directing Board of the Procurement and Assignment Service with the aid of the State Committees of the Procurement and Assignment Service and other agencies and on agreement with the State Boards of Registration and Education in Medicine and Dentistry.

2. These needs shall be met as far as possible by the relocation of physicians or dentists holding licenses within the State.

3. Whenever possible needs shall be met by taking full advantage of existing provisions for reciprocity between the states and inter-state endorsement.

4. Whenever existing laws make impossible the granting of temporary certificates, state boards should recommend to the Governor and to the state legislatures the earliest possible enactment of the bill designed to make possible the utilization of physicians and dentists under temporary certification.

5. When existing measures for relocation of physicians or dentists prove inadequate State Boards of Registration and Education may request the Directing Board of the Procurement and Assignment Service to certify to them the names and qualifications of physicians and dentists who have volunteered or who may be otherwise available for relocation, at which time also such physicians or dentists may be notified that their names have been sent to the State Boards making such requests.

6. The physician or dentist who accepts relocation shall agree to assignment to the specific area in which services are required and to acceptance of a certificate which limits the duration of such service to the period of the emergency and for such additional time as the State Boards may prescribe.

7. In view of the emergency character of this action, the Committee representatives, the Directing Board of the Procurement and Assignment Service, and the Federation of State Medical Boards of the United States, recommend that fees for such certification be waived or reduced to a minimum.

* * *

Item C*

1. How soon after application will the temporary license be issued?

2. Who will pass on credentials submitted, particularly by foreign medical school graduates?

3. How many votes of the California State Board of Medical Examiners will be required to issue a temporary license? Will special Board meetings be required? Source of funds for transportation of Board members.

4. How long will be the term of the temporary license?

5. Will the holder of a temporary license be required to pay the annual tax, the same as is required of other licentiates? The State of California contributes no support from its General Fund. The Board's funds come entirely from physicians. Amount available is subsequently budgeted by other authorities.

6. What method will be employed to see that the holder:

   a. Ceases practice when his temporary license expires?
   b. Has kept the main office of the Board informed of any change in address or location during the period the temporary license was operative.

7. What penalty will be imposed for his failure to pay annual tax?

8. What procedure will be followed if the holder of a temporary license is guilty of unprofessional conduct?

9. What penalty will be imposed if he has secured his license based on fraudulent credentials?

10. What procedure would be followed if he secured a license based on any government credentials when the records subsequently showed him as a graduate of a "nonrecognized" school?

11. What check will be possible on the temporary licensee's diploma if issued by a so-called "diploma mill"?

12. What disposition will be made in the instance of the following:

   a. Those who have failed to pass a California State Board examination?
   b. Those who may have a criminal record here or elsewhere?
   c. Those whose license to practice has been revoked either in California or elsewhere?
   d. Those reported as engaged in narcotic irregularities in California or elsewhere?

13. How will cancellation of temporary license be enforced?

14. Attention is called to the fact that possession of medical college diploma as well as medical license, etc., are not conclusive. For cases of history of fraudulent credentials, see:

Phillips, James H., A.M.A. Jour., Sept. 12, 1942, p. 145.

Raffelson, Aaron W., A.M.A. Jour., May 24, 1941, p. 2424.

Pamphlet entitled, "Fraudulent Credentials," by Charles B. Pinkham, M. D.

* * *

Item D*

Section 1 authorizes the granting of a temporary admission to practice. This will have to be very carefully guarded lest the practice of medicine be opened to everyone, either foreign or domestic, who seeks to practice in California, whether by purchased diploma or by experience in other states. In many states, such as Texas and Oklahoma, not excepting Massachusetts, persons in the past have been licensed to practice without medical diplomas. This is similar to the procedure reported in China, where all one has to do is to announce: "I am a doctor" and proceed to practice.

Page 2 contains a draft of proposed legislation to accomplish the above mentioned "temporary licensing" and also provide for "temporary relocation" of present licentiates. Referring to the first paragraph of page 2, providing for "temporary admission to practice in the State of physicians . . . licensed as such outside the State," this opens the door to everyone licensed to practice in States and Territories of the United States and everyone licensed to practice in any foreign country. We are wondering what means will be taken to "temporarily relocate" licensed physicians and surgeons and who will pay the cost of transportation, as well as the expenses of physicians until their income is satisfactory, for instance, in the case of San Francisco physicians supposed to locate in out of the way places such as Paradise Valley, etc.

Section 2 provides for "power to provide for the temporary admission to practice medicine . . . in this State," this to be accomplished by State Boards assuming power "by general regulations or specific orders . . ." and the natural inquiry is as to who issues the orders. It certainly will not be interstate, unless the legislature passes a law to that effect. Do these "specific orders" refer to "regimentation" from headquarters in Washington, D. C.?

Section 2 provides for "temporary emergency certificates," but no mention is made as to the duration of such

* Queries in re: California Law.

* Some comments and questions which may arise on law proposed by the American Federation of State Medical Boards. See Item A for draft of the proposed law.

32 Jacob M. Leonard (R)—470 Hawkins Street, Hollister
33 Fred Weybret (R)—Star Route, Soledad
34 J. G. Crichton (D)—752 Buckingham Way, Fresno
35 S. L. Heisinger (D)—Route 4, Box 90E, Fresno
36 C. L. Guthrie (D)—627 Mill Street, Porterville
37 Alfred W. Robertson (D)—1524 Garden Street, Santa Barbara
38 Walter J. Fourt (R)—315 Lupin Way, Ventura
39 Thomas Harold Werdel (R)—2200 Pine Street, Bakersfield
40 William H. Rosenthal (D)—409 South Boyle Avenue, Los Angeles
41 Julian Beck (D)—423 Hagar Street, San Fernando
42 Everett G. Burkhalter (D) — 11005 Morrison Street, North Hollywood
43 C. Don Field (R)—1552 Ridgeway Drive, Glendale
44 John B. Pelletier (D)—248 South Olive Street, Los Angeles
45 Thomas J. Doyle (D)—4333 Griffin Avenue, Los Angeles.
46 Glenn M. Anderson (D)—582 North Hawthorne Boulevard, Hawthorne
47 Willis Sargent (R)—300 Bellfontaine, Pasadena
48 T. Fenton Knight (R)—4850 Oakwood Avenue, La Canada
49 Lee T. Bashore (R)—250 Live Oak, Glendora
50 Thomas M. Erwin (R)—1425 South Central Avenue, El Monte
51 Elwyn S. Bennett (D)—918 South Fraser Avenue, Los Angeles
52 Jonathan J. Hollibaugh (R)—6908 Rugby Avenue, Huntington Park
53 Lothrop Smith (R)—568 North Milton Drive, San Gabriel
54 John B. Knight (R)—5224 Maywood, Eagle Rock
55 Vernon Kilpatrick (D)—1246 South Hope Street, Los Angeles
56 Ernest E. Debs (D)—2324 Teviot Street, Los Angeles
57 Franklin J. Potter (R)—3277 Primera Avenue, Hollywood
58 Frank J. Waters (R)—959 Keniston Avenue, Los Angeles
59 Charles W. Lyon (R)—604 North Oakhurst Drive, Beverly Hills
60 Jesse Randolph Kellems (R)—454 Cuesta Way, Bel Air, Los Angeles
61 Lester A. McMillan (D)—2726 Forrester Drive, Los Angeles
62 Augustus F. Hawkins (D)—220 East 46th Street, Los Angeles
63 Don A. Allen (D)—3867 Degnan Boulevard, Los Angeles
64 John C. Lyons (R)—3208 Bellevue Avenue, Los Angeles
65 John W. Evans (D)—4813 South Western Avenue, Los Angeles
66 Jack Massion (D) — 846 East Seventy-seventh Street, Los Angeles
67 Clayton A. Dills (D)—15145 South Vermont Avenue, Gardena
68 Vincent Thomas (D)—722 West Twentieth Street, San Pedro
69 Ralph C. Dills (D)—1505 North Spring Street, Compton
70 Lorne D. Middough (D)—233 Roswell Avenue, Long Beach
71 Fred N. Howser (R)—3940 Linden Avenue, Long Beach
72 R. Fred Price (R)—303 West Emporia Avenue, Ontario
73 Douglas P. Armstrong (R) — Palmetto Street, Redlands
74 Clyde A. Watson (R) — 273 North Harwood Street, Orange
75 Sam L. Collins (R)—North Cypress Avenue, Fullerton
76 Nelson S. Dilworth (R)—Route 1, Box 18, Hemet
77 Harvey E. Hastain (R)—277 West K Street, Brawley
78 Frederick H. Kraft (R)—1889 Bacon Street, San Diego
79 Kathryn T. Niehouse (R)—4889 Bancroft Street, San Diego
80 Charles W. Stream (R)—664 Del Mar Avenue, Chula Vista

(R) *Republican Assemblymen 44*
(D) *Democratic Assemblymen 36*

80

CALIFORNIA'S MEDICAL PRACTICE ACT—ARE TEMPORARY LICENSES TO PRACTICE DESIRABLE?

The items which appear below are referred to in brief editorial comments which appear on page 2. ("Item A draft" was submitted by the American Federation of Medical Boards.)

Item A

A draft of proposed legislation to authorize and provide for the temporary admission to practice in the States of physicians and dentists to protect the health of the civilian population during the war emergency period.

Be it enacted . . .

Section 1. *Purpose.* A serious public emergency exists or may exist in this State because of the demands of the armed services for physicians and dentists. Coöperation on the part of the State, with certain Federal agencies, such as the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians of the War Manpower Commission is imperative, so that temporary relocation of physicians and dentists may be accomplished, to overcome acute shortages in specific localities from time to time. For the protection of the health and welfare of the people of the State, power to provide for the temporary admission to practice in the State of physicians and dentists, licensed as such outside the State, is hereby conferred upon the State Board of Medical Registration and Education* and the State Board of Dental Registration and Education* upon conditions and under regulations prescribed by them.

Section 2. *Power to provide for the temporary admission to practice medicine and dentistry in the State.* To accomplish the purpose set forth in Section 1, and notwithstanding any inconsistent provision of law, the State Boards of Registration and Education in Medicine and Dentistry* shall have power by general regulations or specific orders, to issue temporary emergency certificates to such physicians and dentists, licensed as such outside the State, as they shall find qualified to practice as such in the State during such emergency. The holder of any such temporary certificate shall be privileged during the term specified therein, unless sooner revoked, to practice his profession within the State, subject however, to all laws of the State generally applicable to the practice of such profession and to such regulations, restrictions, and area limitations as the State Boards* may make or impose as to them or any of them and their practice within the State.

* Substitute appropriate licensing agency or group existing in your State.

Item B

Statement of Principles to be recommended to the respective State Boards of Registration and Education in Medicine and Dentistry.

1. The need for relocation or assignment of physicians or dentists shall be determined by the Directing Board of the Procurement and Assignment Service with the aid of the State Committees of the Procurement and Assignment Service and other agencies and on agreement with the State Boards of Registration and Education in Medicine and Dentistry.

2. These needs shall be met as far as possible by the relocation of physicians or dentists holding licenses within the State.

3. Whenever possible needs shall be met by taking full advantage of existing provisions for reciprocity between the states and inter-state endorsement.

4. Whenever existing laws make impossible the granting of temporary certificates, state boards should recommend to the Governor and to the state legislatures the earliest possible enactment of the bill designed to make possible the utilization of physicians and dentists under temporary certification.

5. When existing measures for relocation of physicians or dentists prove inadequate State Boards of Registration and Education may request the Directing Board of the Procurement and Assignment Service to certify to them the names and qualifications of physicians and dentists who have volunteered or who may be otherwise available for relocation, at which time also such physicians or dentists may be notified that their names have been sent to the State Boards making such requests.

6. The physician or dentist who accepts relocation shall agree to assignment to the specific area in which services are required and to acceptance of a certificate which limits the duration of such service to the period of the emergency and for such additional time as the State Boards may prescribe.

7. In view of the emergency character of this action, the Committee representatives, the Directing Board of the Procurement and Assignment Service, and the Federation of State Medical Boards of the United States, recommend that fees for such certification be waived or reduced to a minimum.

* * *

Item C*

1. How soon after application will the temporary license be issued?

2. Who will pass on credentials submitted, particularly by foreign medical school graduates?

3. How many votes of the California State Board of Medical Examiners will be required to issue a temporary license? Will special Board meetings be required? Source of funds for transportation of Board members.

4. How long will be the term of the temporary license?

5. Will the holder of a temporary license be required to pay the annual tax, the same as is required of other licentiates? The State of California contributes no support from its General Fund. The Board's funds come entirely from physicians. Amount available is subsequently budgeted by other authorities.

6. What method will be employed to see that the holder:

   a. Ceases practice when his temporary license expires?
   b. Has kept the main office of the Board informed of any change in address or location during the period the temporary license was operative.

7. What penalty will be imposed for his failure to pay annual tax?

8. What procedure will be followed if the holder of a temporary license is guilty of unprofessional conduct?

9. What penalty will be imposed if he has secured his license based on fraudulent credentials?

10. What procedure would be followed if he secured a license based on any government credentials when the records subsequently showed him as a graduate of a "nonrecognized" school?

11. What check will be possible on the temporary licensee's diploma if issued by a so-called "diploma mill"?

12. What disposition will be made in the instance of the following:

   a. Those who have failed to pass a California State Board examination?
   b. Those who may have a criminal record here or elsewhere?
   c. Those whose license to practice has been revoked either in California or elsewhere?
   d. Those reported as engaged in narcotic irregularities in California or elsewhere?

13. How will cancellation of temporary license be enforced?

14. Attention is called to the fact that possession of medical college diploma as well as medical license, etc., are not conclusive. For cases of history of fraudulent credentials, see:

Phillips, James H., A.M.A. Jour., Sept. 12, 1942, p. 145.

Raffelson, Aaron W., A.M.A. Jour., May 24, 1941, p. 2424.

Pamphlet entitled, "Fraudulent Credentials," by Charles B. Pinkham, M. D.

* Queries in re: California Law.

* * *

Item D*

Section 1 authorizes the granting of a temporary admission to practice. This will have to be very carefully guarded lest the practice of medicine be opened to everyone, either foreign or domestic, who seeks to practice in California, whether by purchased diploma or by experience in other states. In many states, such as Texas and Oklahoma, not excepting Massachusetts, persons in the past have been licensed to practice without medical diplomas. This is similar to the procedure reported in China, where all one has to do is to announce: "I am a doctor" and proceed to practice.

Page 2 contains a draft of proposed legislation to accomplish the above mentioned "temporary licensing" and also provide for "temporary relocation" of present licentiates. Referring to the first paragraph of page 2, providing for "temporary admission to practice in the State of physicians . . . licensed as such outside the State," this opens the door to everyone licensed to practice in States and Territories of the United States and everyone licensed to practice in any foreign country. We are wondering what means will be taken to "temporarily relocate" licensed physicians and surgeons and who will pay the cost of transportation, as well as the expenses of physicians until their income is satisfactory, for instance, in the case of San Francisco physicians supposed to locate in out of the way places such as Paradise Valley, etc.

Section 2 provides for "power to provide for the temporary admission to practice medicine . . . in this State," this to be accomplished by State Boards assuming power "by general regulations or specific orders . . ." and the natural inquiry is as to who issues the orders. It certainly will not be interstate, unless the legislature passes a law to that effect. Do these "specific orders" refer to "regimentation" from headquarters in Washington, D. C.?

Section 2 provides for "temporary emergency certificates," but no mention is made as to the duration of such

* Some comments and questions which may arise on law proposed by the American Federation of State Medical Boards. See Item A for draft of the proposed law.

certificate. After the "duration," the individual who has been practicing in a locality under such a temporary certificate, will probably seek every possible aid to continue such practice and the argument will be advanced that if he was good enough to practice during the "emergency," he is certainly good enough to practice in a specific locality after the "emergency" is over. There is no doubt but that he will muster much individual legislation along that particular line. At least, past experience so indicates.

Section 2 provides that the holder of such a "temporary certificate" shall be privileged to practice within the State, "subject to all laws of the State generally applicable to the practice . . ." Phraseology such as this will cause no end to the present difficulties in law enforcement. Disciplinary action in citing temporary certificate holders will be ineffectual. Citation of violators of narcotic laws, etc., will also be ineffectual.

Paragraph 7 of the "Principles," refers to the granting of temporary certificates in the State of California on waiver or reduction to a minimum of the fee established by law. Inasmuch as the California Board of Medical Examiners exists only on the income from the fees that it collects, it would not be long before the financial condition might make further functioning impossible.

COMMITTEE ON MEDICAL ECONOMICS

Trust Conviction of Medical Body Up to High Court

Washington, Dec. 11.—(AP.)—Validity of the American Medical Association's conviction on a charge of violating the Sherman Anti-Trust law by alleged activities against a group-health organization in the District of Columbia was at issue today in arguments before the Supreme Court.

One of the disputed points was whether practicing medicine is a trade or a profession. The Sherman act prohibits combinations in "restraint of trade."

The Association and an affiliate, the Medical Society of the District of Columbia, were convicted in the United States district court here. A $2500 fine was imposed against the national organization and a $1500 fine against the local society.

Conspiracy Charged

They were accused of conspiring against Group Health Association, Inc., described as a nonprofit coöperative association of Government employees.

Thurman Arnold, assistant attorney general in charge of anti-trust law enforcement, contended in a brief filed with the court that "the conspiracy to prevent Group Health from successfully carrying on its business of furnishing medical service to members of the consuming public was a restraint of trade prohibited by the Sherman act."

Defined as Trade

"Group Health," he added, "was engaged in a large scale undertaking to provide medical service in exchange for payment of dues. This exchange of service for money is trade in the primary and most usual meaning of the word."

Seth W. Richardson, Washington attorney for the medical associations, replied that "all of the dictionaries agree that in the broadest meaning ever ascribed to trade to date it has never been understood to include the arts or the learned professions."

Judicial definitions and the legislative history of the Sherman act, he added, demonstrate "inescapably" that the word "concerns only commercial activities and excludes the learned professions."—Oakland *Tribune*, December 11.

Charity Hospitals Not Required to Contribute to Unemployment Insurance Fund, Judge Wilson Rules

In a decision which will affect all charitable hospitals throughout California, Superior Judge Emmet H. Wilson has determined that such hospitals are not employers within the meaning of the California Unemployment Insurance Act and are therefore not required to make contributions to the Unemployment Insurance Fund. The case is said to be one of first impression in California.

Excerpts from the opinion follow:

OPINION

No. 474,695

In the Superior Court of the State of California in and for the County of Los Angeles.

* * *

Seaside Memorial Hospital of Long Beach, a nonprofit corporation, Petitioner, vs. *California Employment Commission, et al.,* Respondents, and *Edith Newby Cope, et al,* Co-Respondents.

* * *

For Petitioner: Musick & Burrell and James E. Ludlam.

Amici Curiae in support of Petitioner: Orrick, Dahlquist, Neff & Herrington.

For Respondents: Earl Warren, Attorney General and John J. Dailey, Deputy Attorney General.

Of Counsel for Respondents: Maurice P. McCaffrey, Glenn V. Walls, Elizabeth Doyle, Forest M. Hill, and Doris H. Maier.

* * *

This is a mandamus proceeding brought for the purpose of requiring respondent California Employment Commission, its members and Director, hereinafter sometimes referred to jointly as "Commission," to reverse its ruling in a tax decision case wherein said Commission held that petitioner, hereinafter sometimes called "Hospital" was an employer subject to the provisions of the California Unemployment Insurance Act, and to make the following rulings: . . .

Petitioner's claim of exemption under section 7(g) of the statute. Section 7 of the California Unemployment Insurance Act provides: "The term 'employment' does not include: * * * (g) Service performed in the employ of a corporation, community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual;" (Stats. 1939, ch. 1039, p. 2850.) This language is identical with that found in section 907 (c) (7) of the Federal Social Security Act which in turn was taken verbatim from section 101 (6) of the Revenue Act of 1934. In 1939 said section 907(c)(7) became section 1607 (c) (8) of the Internal Revenue Code (26 U. S. C. A. sec. 1607, p. 402) with the addition of words not affecting or applicable to this proceeding. . . .

Petitioner's claim of exemption under section 7(g) of the statute. . . .

In order to do charity petitioner must have funds. It is not necessary that a charitable organization originate from or be maintained by means of bequests, donations, and offerings from public moneys, nor need its representatives go on the streets with coin boxes or tambourines soliciting passers-by in order to supply its treasury. It may collect from those who are able to pay for services rendered to them and use the remaining surplus in its charitable work without loss of its status as a charitable corporation. Neither does the fact that petitioner purchased the hospital from a corporation organized for profit militate against its rights and privileges provided by law. Whether petitioner borrowed money for the purpose of constructing a new building and purchasing operating equipment, agreeing to repay the same in installments represented by bonds, or purchased an existing complete plant, paying for it in the same manner, the result is identical. *(Virginia Mason Hospital Ass'n v. Larson,* 9 Wash. (2d) 284, *supra; Commissioner of Internal Revenue v. Battle Creek, Inc.,* 126 Fed. (2d) 405, *supra.)* Neither a certain defined amount of its expenditures for charity nor the percentage thereof in relation

to its income or to its other expenses is the criterion. Not all of the patients need be treated free of charge. The number of free beds maintained by petitioner is only relative and is not important. There is no restrictive terminology in the statute from which it can be inferred that the legislature intended that a charity must be extensive in order to qualify under the law. To tax a nonprofit hospital is to place a direct tax on the sick and injured. The stipulated facts and the applicable law demonstrate that petitioner is organized exclusively for charitable purposes, that it is operated exclusively for such purposes, that no part of its net earnings inures to the benefit of any private shareholder or individual, and that by reason of the provisions of section 7 (g) of the act it is exempt from taxation under the statute and from the jurisdiction of respondents.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

The Los Angeles and San Francisco County Medical Societies are two component county units of large membership and interests.

At the close of the calendar year, the retiring officers presented reports in which current activities received comment.

Since most county societies are called upon to solve problems of somewhat similar qualitative nature, C. and W. M. presents here, for their suggestive value concerning county society work, the reports of Doctor John W. Cline, retiring president of the San Francisco County Medical Society, and Doctor Lewis A. Alesen, Secretary of the Los Angeles County Medical Association:

San Francisco County Medical Society

Annual Report of the President

The by-laws of the Society require that the president render, at the annual meeting, a report of the Society's activities during the preceding year. Having had the honor of being your president during the past year, I submit this report. There is much to be covered, but I shall make it as brief as possible and, to this end, shall divide it into several sections.

ACTIVITIES DIRECTLY ASSOCIATED WITH THE WAR

Members in Service.—About three hundred members of the Society have requested leaves of absence for military duty. A sufficient number of additional members have joined the Service without the formality of requesting leave to bring the total of active members now in the service to about one-third of the entire Society.

Procurement and Assignment.—The State Procurement and Assignment Service under the able chairmanship of Harold Fletcher has met the difficult problem of enlistment in the Service and the maintenance of adequate civilian medical care in an orderly and efficient manner. It has had the complete coöperation of the Society's Committee on Procurement and Assignment, headed first by Doctor Fletcher himself and subsequently by Doctor Moore and Doctor Ebright. This committee has done splendid work and is deserving of commendation.

Selective Service.—Members of the Society have continued to render their services to the draft boards and the various phases of the selective service program generously and without compensation.

Special Service Fund.—The Special Service Fund with which you are all familiar now contains about $10,000. The cause is worthy and deserves far greater support than the membership has accorded it to date. It is to be hoped that the Society will respond with increasing interest and contributions.

EMERGENCY ACTIVITIES ARISING FROM THE WAR

Disaster Program.—Under the guidance of Henry Gibbons, III, acting first as chairman of the Medical Division of the Red Cross Disaster Program and later as the Medical Director of Civilian Defense, the Society has furnished the personnel of the hospital and station organizations for the care of the civilian population in the event of disaster. The plans have been developed and improved in constant consultation with officers of the Society. Recent improvements in the organization of this service have greatly increased its efficiency and make it more adaptable to any type of emergency.

Demands in Private Practice.—The reduction of numbers of physicians in private practice and the population increase in the community have placed additional burdens of practice upon those who have remained behind. The Society has been responsible for publicizing this fact and has urged that patients be as considerate as possible in making demands for professional services. We have asked that they give due consideration to the elements of necessity and time in making requests for service.

Health Service System.—After four years of negotiations, and at times, acrimonious conflict, with the Health Service System, a new era is apparent. There has been sufficient alteration in the personnel and attitude of the Health Service Board that coöperation in the solution of mutual problems now seems assured. The Board has made upward revisions in the rates for subscribers which should accomplish a 100 cent unit. It has given the Society assurance and impressed upon its own members that no satisfactory operation of the system can be expected until and unless the physicians rendering care to the municipal employees are paid in full. With this principle established, the major source of friction has been removed. In view of the friendly and coöperative spirit of the board and its medical director, A. S. Keenan, such minor difficulties as may arise should be easily adjusted without controversy. The committee headed by Stanley Mentzer has rendered a real service to the Society.

Well Baby Clinics.—For years, so-called Well Baby Clinics operated by city and private agencies, have proceeded to render partial and in some instances extensive medical care to the community without adequate supervision and without social service eligibility requirements or investigation. The Society has taken the position that it is desirous of furthering the care of the deserving but that extension of free care to the undeserving is an imposition upon the taxpayers, staffs of these clinics and the medical profession. The matter was laid before Mr. Thomas Brooks, Chief Administrative Officer of the city, and he has directed the inclusion of social service costs for one of these clinics in the next budget. If the results of this investigation establish what appears to be the actual situation, we can look forward to the time when these agencies will be brought under social service rules comparable to those of the San Francisco Hospital.

C.P.S.—The Society has continued to give excellent support to the California Physicians' Service, and the wisdom of this course is now clear. C.P.S. has grown and has expanded into new fields. It has taken over the medical care in the federal housing projects in the San Diego, Los Angeles, Marin and Vallejo areas and is soon to add others. C.P.S. has already changed many of its contracts and is in the process of changing most of the remainder from full to limited coverage. This change has been reflected in some increase in the unit value and material improvement will soon follow.

The short-sighted attitude of certain county societies toward C.P.S. is scarcely understandable. One society has already paid for it by having a well-financed, well-

organized, closed staff organization set up in its community. Such groups are bound to result in ultimate detriment to both the patient and the profession. Let us hope that the mistakes of the past will not be repeated.

As the war progresses, particularly after its conclusion, C.P.S. will prove of inestimable value and will stand as a monument to the vision and public spirit of the medical profession.

Hospital Conference Liaison Committee.—There has been increasing coöperation between the Hospital Conference and the County Society. Some time ago, the Conference asked that a liaison committee of three members from each body be established. This committee was created and a number of meetings have been held. One of the concrete results of this coöperative endeavor was prevention of the approval of a proposed surgical indemnification contract which was to have been issued by the Hospital Service of California in competition with C.P.S.

Standing and Special Committees.—The standing and special committees of the Society have done their work well. Time does not permit a discussion of all of these activities. The reports of these committees will be given tonight or published in the *Bulletin.*

Membership.—The active membership of the Society has been reduced. The number of new members during the past year is 104. When this is balanced against a loss of more than 300, it is apparent that a substantial reduction in total membership has taken place. The responsibility of those who remain has been consequently increased. In spite of the increased demands of practice, we must bear in mind that the County Medical Society is our organization and the representative of the medical profession in San Francisco. We must continue to support it in every way possible.

* * *

I wish to express my appreciation at this time for the hard work and complete coöperation of the officers, directors, committees and employees of the Society.

L. H. Garland, who is shortly to enter the navy, finishes his period of service as secretary of the Society, January 1st. While I hesitate to single out any individual member for special commendation, I cannot refrain from doing so in his case. He has established a standard for future secretaries in the zealous performance of his duties. His active and inquiring mind has been responsible for many of the projects of the concluding year and his capacity to translate thought into accomplishment has resulted in their completion.

Miss Lillian Moses has continued to render her customary excellent service to the Society as the executive of our offices. We are very fortunate to have her in this position. She has been ably assisted by Miss Nina Hansen.

For the past two years, we have had the services of Messrs. Lee and Losh in our public relations problems. It is probable that the Society's budget will permit continuance of their services. In many instances, their aid and counsel have been extremely valuable. We would regret the necessity of discontinuing their services, and are happy to know that we shall be able to call upon them at any time should occasion demand it.

The Woman's Auxiliary has given a splendid account of itself as usual. It has furnished the drivers for the Blood Bank delivery wagon and has solved a very difficult problem, not only for us but for the hospitals and the community at large. It gave splendid assistance in the ill-fated campaign for Proposition No. 3. Its work, in conjunction with that of Doctor Gaffney's committee, is largely responsible for the good plurality rolled up in San Francisco.

I am deeply appreciative of the honor you bestowed upon me by making me your president for 1942, and with this account of stewardship, I tender you my thanks.

December 8, 1942. JOHN W. CLINE.

Los Angeles County Medical Association

Annual Report of the Secretary

War, as we are well aware today, has a most far-reaching effect upon the Doctor of Medicine and upon the medical associations to which he belongs.

Never, perhaps, is there a greater need for medical organization than in time of war. Long before the attack on Pearl Harbor a year ago, your County Medical Association, aware of the probability of this country entering the world conflict at an early date, made plans for that eventuality.

So that your Association would be able to carry on its vital functions in behalf of public health and welfare and to serve the Doctor of Medicine and to protect the profession of Medicine in the great social and economic changes incident to war, first things were considered first.

Financial Status.—No organization can function effectively unless its financial status is sound. World War No. I taught medical societies throughout the country a severe lesson. Through the loss of great numbers of members many of these societies were so crippled financially that their activities, so necessary at such a time, became practically negligible.

As secretary-treasurer of the Los Angeles County Medical Association, I am most happy to report at this time that the financial status of your Association is excellent, due to financial planning more than three years ago for the possibility of war.

The finances of the Association have been carefully guarded. Income from dues, *Bulletin* advertising, and from income property has been conserved, and expenditures approved for only those activities deemed necessary and constructive.

No small part of the income of the Association is derived from the advertising pages of the *Bulletin.* You will all realize, I am sure, that during the past year all business has been severely affected by the war effort. However, in spite of this, and in spite of the fact that many of our nationally known publications have suffered a loss of advertising revenue, an increase in advertising revenue was achieved for the *Bulletin.*

However, the cost of publishing the *Bulletin* has shown an increase this past year due entirely to the increase in cost of paper, ink, and printers' charges. The *Bulletin,* however, at the end of the year will, as usual, show a most appreciable income to be used to further the activities of your Association.

Other income from annual dues is shown from *rentals of the property* at 1930 Wilshire Boulevard, in the sum of $12,500 a year. As in past years this item of income is used for the maintenance of the Library of the Association.

Constituting a large part of the income, of course, are *dues from members.* The Los Angeles County Medical Association collects from its members both its own and dues for the California Medical Association. This year the dues of the California Medical Association were $15.00. Dues for the Los Angeles County Medical Association also were $15, making a total of $30.00.

Membership.—At the beginning of the current year the dues-paying members of the Los Angeles County Medical Association numbered 2,850. Five hundred thirty-two of these members have been called to military service and thereby are exempt from the payment of dues. This number will increase. New members have been added, of course, during the year, but not in a number to com-

pensate for those going into service.

Dues.—This loss in dues paying members because of the war was given serious consideration by the House of Delegates of the California Medical Association at its meeting in Del Monte last May. That House of Delegates unanimously voted an increase in the dues of the California Medical Association of $5.00 for 1943. This was a necessary action to provide finances for the California Medical Association to carry on its vital activities for the year 1943.

The Board of Trustees of the Los Angeles County Medical Association at its November meeting, voted an increase in the Los Angeles County Medical Association dues of $2.50, making the dues of the Los Angeles County Medical Association $17.50 for the year 1943.

Economic and Social Problems.—All of us who read understand too well the problems that the profession of medicine is confronted with today. These problems are of great economic and social import. The profession of medicine has a grave responsibility . . . a responsibility that it accepted ages ago and one that it cannot relinquish. That responsibility is the health and welfare of the people the profession serves. So that the people may be served, it is essential that the profession of medicine itself be maintained. With many of our members serving with the armed forces and unable to lend their support in the work of maintaining for us and for them when they return, our professional integrity, it appears axiomatic that we who remain at home must carry a greater burden in this effort than we ever have carried in the past. A nominal increase in annual dues, after careful consideration, will appear but a small part of this burden.

Many of the activities of the Association carried on in past years have, since the outbreak of the war, been given more or less a place of secondary importance. The offices of the Association, beginning with the outbreak of the war, have been busily engaged in wartime activities, especially as relates to the creation, and staffing and later manning of the medical personnel, of the many casualty stations in this county.

The office of the Association has given a great deal of assistance to the Procurement and Assignment Committee. Details of these activities have appeared from time to time in the *Bulletin* of the Association, and should need no detailed comment here.

One of the important considerations to the members is the membership status of the Association. The loss of dues-paying members through death, leaves of absence, retirement, etc., totals 628, leaving as of November 1, 1942, a total of 2,222 dues-paying members. Each day members are leaving for military service. How many will be called before the end of 1943 we are unprepared to say.

The various standing and special committees of the Association have been exceedingly active. Our Council and our Board of Trustees have recognized the gravity of the situation that has existed during the past year and have met the various problems as they have arisen in a diligent effort to solve them.

Hospital Problems.—Especially active has been the Committee on Hospitals, Dispensaries and Clinics, under the chairmanship of Carl L. Mulfinger, M. D., which has met many times with representatives of the nursing profession and hospital officials in efforts to meet a most serious situation in Los Angeles County because of the great shortage of hospital beds and hospital personnel. Detailed reports of the accomplishments of this committee have appeared in the *Bulletin.*

Lay Publicity.—The Committee on Public Policy and Relations, under the chairmanship of Paul A. Quaintance, M. D., has, as in the past, done very commendable work in obtaining speakers on pertinent subjects for many lay groups.

While the activities of the Association have been directed largely to assist in the war effort, other important activities were not neglected, among them maintenance of the standards of the practice of medicine.

The facilities of the Association were used as usual by the various sections and specialty societies for their scientific meetings.

Members in Military Service.—The Los Angeles County Medical Association is in an excellent position to maintain for the duration its essential purpose in this community. We must not forget that the end of this year may find a total of 700 of our active members in military service. We must not forget that these members, while exempt from the payment of dues, are still our members and will expect their Association—and that means each member of the Association—to carry on as in the past, to protect the profession of medicine so that when they return, they will not find that we have been wanting in accepting our real responsibility.

L. A. ALESEN.

Shall Organized Medicine Lead or Follow?

The following are excerpts from an address by George W. Cottis, M. D., Jamestown, N. Y., President, Medical Society of the State of New York, given before the First District Branch, Medical Society of the State of New York, St. Joseph's Hospital, Yonkers, New York, Wednesday, October 7, 1942:

I have not the answers to the questions which follow, neither, I venture to say, has anyone else. But the answers must be found and they must come from the only body of men having the necessary knowledge, the medical profession.

1. How can we bring a twelve-cylinder standard of medical services to a man who can barely afford a bicycle?

2. How shall we extend preventive measures to the whole population and so lessen the need for curative medicine?

3. How shall we provide institutional care for hopeless cancer patients?

4. How furnish enough convalescent homes to relieve our general hospitals of the burden of caring for patients with chronic ailments?

5. How provide proper care to our civilian population when the most virile one half of us are in the armed forces?

6. How care for defense workers and workers in general industry? How meet the demands of thousands of workers and their families today in an area where yesterday was only a scattered rural population?

7. How protect the public from its own folly in patronizing quacks?

8. How force venal politicians to pass such legislation as the Copeland bill to check false and dangerous labeling of drugs and foods?

9. How clear our own house of legalized quacks and fakers?

10. How force the speeding up of the production of doctors by casting out deadwood from curricula and rearranging courses?

11. How encourage and finance scientific research after large fortunes have been eliminated by government policy and private endowments are discontinued?

12. How are we to maintain our own freedom of thought and our own initiative in finding the answers to all of these questions in the face of a regimentation which already has replaced freedom of action in all industry?

As a nation we are beginning to appreciate the tremendous cost of the wishful thinking, wilful blindness and inexcusable ignorance of world affairs which resulted in our unpreparedness to meet what was plainly inevitable. As a profession we should profit by that experience and make sure that we know what is happening or is about to happen to us.

Society is an organism subject to all the laws of evolution. Medicine is an organ of vital importance in that

organism. There is of necessity a constant interrelationship between the two, and we cannot appraise our situation apart from that of society as a whole.

We must be aware that the World Revolution is not a revolution in the ordinary sense but a world-wide change as fundamental as that from feudalism to capitalism. Furthermore, we must accept this change as inevitable and very imminent. In fact it is already here. Its groundswell has been rolling toward us for many years, but it is only now when the wave has broken on our own shores that we are aware of its strength.

The "New Order" of the Nazis and Japs is only one manifestation of the change. The Russian experiment, the Swedish "Middle Way" and the American New Deal are all equally symptomatic of a new way of life.

It is with this background that we must consider what is ahead of us. We are paddling our canoe down a river with many bends and the current is running faster and faster. To drift blindly may lead to disaster. We cannot turn back, but we can stop paddling long enough to climb to some high point and see what is before us. If we can rise far enough we may get a bird's eye view. What would it show us?

Of course our nearest view would be that of the greatest nation on earth hamstrung during the critical prewar years by the myopia of its leaders, preparing terribly late to give its life blood to escape slavery. The wider view would be that of a world at war. But under the smoke and fire of battles we might see all the peoples of the world moving like a tidal wave in one direction. That direction is toward a new form of society in which independence is replaced by dependence and freedom traded for security. The leaders who promise these are the ones the people follow. The security they seek and demand is security against want, hardship and illness. That is the negative way of saying that they demand assurance of shelter, food, clothing, recreation and medical care, without much regard to their ability to earn them.

Now where do we, as a profession, fit into the picture? Most of our deliberations have been concerned with the question, "How are we to meet the issues that confront us?"

The primary question should be not "How?" but "What?" What are the demands of our changing social organization?

What portion of an individual's welfare is to be the concern of the State and what part is to be left to personal intiative?

What shall be the relation of organized medicine to the State and to the public?

What are the defects in our present system of medical care?

What changes or innovations are necessary to provide the highest standards of health for our people?

What is to be our own procedure in the circumstances? Are we to dig in our heels and pull against the trend or are we to set the objectives and assert and prove our right to leadership?—*"Medical News"* bulletin of the Medical Society of the State of New York, October 7, 1942.

Attendance at Meetings of District Medical Societies: Some New York Statistics

The Medical Society of the State of New York recently gave some statistics concerning attendance at district medical meetings, with a break-down of the age-groups of physicians who registered. The figures are naturally of interest to members of other state medical associations:

DISTRICT BRANCH ATTENDANCE

An index of the impact of the war upon the Medical Society of the State of New York may be found in the attendance records of the District Branch meetings for this as compared with last year:

In 1941, the total attendance was 960; this year, 594.

In 1941, the average age of those who came was 47.39 years; this year, 51.98 years.

In 1941, the prominent decade was 35-44; in 1942, 45-54.

In 1941, the number under 45 years was 460; in 1942, 145.

In 1941, the number who were aged 45 was 25; in 1942, 25.

Repeaters *in the 7th decade:* 1941, 0; 1942, 9.

A further breakdown of age groups by periods of five years shows:

45-54=183, or 30.81 per cent in 1942; 242, or 25.21 per cent in 1941.

55-64=134, or 22.56 per cent in 1942; 155, or 16.15 per cent in 1941.

65-74=93, or 15.66 per cent in 1942; 94, or 9.79 per cent in 1941.

75-84=15, or 2.53 per cent in 1942; 15, or 1.56 per cent in 1941.

85-94=1, or 0.17 per cent in 1942.

It may be noted that the interest and alertness of the physicians of 65 years and older are well shown by this table. These men allow no grass to grow under their feet; they were on deck both this year and last to learn what was new and to signify their willingness, even eagerness, to bear their share of the burden and heat of the day—and the night, too, if need be.

No less interesting is the contrast in the lower age groups in the two years. In the group

25-34 years, 136 attended in 1941; 36 in 1942;—7.69 per cent.

35-44 years, 322 attended in 1941; 132 in 1942; —11.32 per cent.

45-54 years, 242 attended in 1941; 183 in 1942; +5.60 per cent.

Bald and gray heads seemingly will carry on to the limit of their ability, always eager to learn that they may better serve.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Medical Students' Deferment Urged

Brig. Gen. Charles C. Hillman, surgeon general of the U. S. Army, on November 21st, stated that the supply of future physicians required for both the military and civilian effort "must not be curtailed at the source."

Explaining that the lowering of the draft age to 18 created new problems to medical and premedical students, Gen. Hillman expressed hope that the War Department would work out comprehensive plans to assure a continuous supply of new physicians for essential industries and civilian communities.

Gen. Hillman, speaking at an American Medical Association conference yesterday, said that unless provision was made to assure a minimum of two years' premedical education for those planning to enter medical schools, "only women and the physically unfit would be able to enter medical schools."

To Train M.D.'s

Chicago.—(UP.)—The Council on Medical Education and Hospitals of the American Medical Association has adopted resolutions to shorten the period required for a M. D. degree from eight years after graduation from high school to five years. This shortened curriculum, as reported by the A.M.A. *Journal*, will be in force for the duration of the war.—Oakland *Tribune*, December 20.

Army Medical Plan Enlists U. C., Stanford

The medical and dental schools of the University of California and Stanford are scheduled to take part in a special training program under which several thousand Army medical and dental officers will receive specialized training, Secretary of War Stimson announced in Washington, D. C., on December 31st.

From 200 to 400 officers will be selected for each class, which will begin today.

"Distribution of professional medical men trained for

medical and surgical specialties," the Secretary said, "has proved inadequate to meet the demands of war. But a number of Army Medical Corps officers can, with a short intensive course, become qualified to help eliminate the deficit in that specialty."

Chancellor Ray Lyman Wilbur, of Stanford, said yesterday that the Stanford medical school is already training a group of some 20 Army doctors in thoracic surgery.

Who'll Fight—and Who'll Study—U. S. to Decide

College to Go on Wartime Footing as Manpower Crisis Becomes Acute

Washington dispatches put the query, "Who is going to college" as a question that is rapidly becoming one of the big problems of wartime.

With the draft lowered to include 18 year olds, the question became, so far as young men are concerned, largely one for the Government rather than the individual to determine.

Part of the answer already has been given in the Army and Navy announcements of their training programs. The rest is yet to come and may stir up a lively debate in the new Congress.

Paul V. McNutt, the war manpower commissioner, gave a hint of what high officials have in mind when he announced this week that more than 150,000 college men would get temporary draft deferment to continue medical, engineering and other specialized scientific training.

Program Incomplete

The deferment will last until the end of the school year and meantime, McNutt said, plans will be worked out for the education of a number of civilians by Government financing. . . .

Bay Colleges Waiting on Army and Navy

Bay Area colleges today awaited identification by the War and Navy Departments of the 200 to 300 institutions which it was announced in Washington, will be used to give specialized training to young men in the armed services. . . .

In Washington, Secretary of War Stimson said the new joint Army-Navy program would go far toward temporarily destroying liberal education in America but would have no permanently bad effect. . . .

School at Del Monte

A pre-flight school announced recently for Del Monte, accommodating about 1,500 students using facilities of the Hotel Del Monte, will be opened about February 4, the Navy said today. Its commanding officer will be Captain George Washington Steele, USN (Ret.), who has headed the St. Mary's Pre-Flight School since it opened. . . .

The Army and Navy will contract with the selected institutions to furnish instruction in prescribed courses and to furnish housing and feeding facilities. Men sent to college by the services will be on active duty and wear uniforms, receive service pay and be subject to discipline. . . .

Special Provisions

Special provisions are made for enlisted reserves. Medical and premedical students, four-year ROTC students and junior students in the enlisted reserve taking engineering courses, will be continued on an inactive status until the end of the next academic semester which begins after today. All other enlisted reserve students will be called to active duty at the end of the current semester. On completion of basic military training, they will be eligible for selection for academic training under the program.—San Francisco *News*, December 17.

U. S. Plans to Subsidize Medical Students

Washington, Dec. 23.—(UP.)—The War Manpower Commission announced in December that it was working on plans to subsidize men and women in the study of medicine and other sciences to fill civilian wartime needs and prepare for the postwar period.

The Army and Navy already have publicized plans for training members of the armed forces to meet their needs.

The number of persons to be given higher education through the WMC program depends on how much money is appropriated for that purpose by Congress. WMC Chairman, Paul V. McNutt, said the request would go to Congress next month.

How young men and women will be chosen for WMC-subsidized education has not been decided, officials said, but the emphasis will be on the education of doctors, chemists and engineers. . . .

Enrollment of Universities Drops 13.9 Per Cent

Cincinnati, Dec. 21.—(AP.)—Dr. Raymond Walters, president of the University of Cincinnati, today reported sharp decline in attendance in 667 American approved colleges and universities during 1942.

"The university law schools and graduate schools of arts and sciences were hit the hardest."

Declines of approximately 9.5 to 10 per cent in full-time students, 13 9-10 per cent in grand totals, including part-time and summer session attendance were noted in Walter's twenty-fourth annual enrollment survey for School and Society and Educational Weekly.

The 667 institutions had 746,922 full-time students and a grand total of 1,075,849 as of November 1, Walters reported.

Freshman enrollments were down 1.7 per cent, but freshman enrollments during the fall in technological institutions were up 9.2 per cent.

A drop of 22.5 per cent in attendance at 78 teacher colleges was reported. Law schools in 83 universities declined 51.3 per cent and graduate schools 29.9 per cent.

Considering full-time enrollments, the University of California again headed the list with 18,364 students.—San Francisco *Chronicle*, December 22.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

San Bernardino County Hospital

Patients Able to Pay for Hospitalization Must Do So

Persons who are able to pay for services and treatment received at the San Bernardino County Hospital must do so or face the possibility of court action with the county suing to recover.

This is the effect, observers pointed out, of the revision of the hospital's collection system following recommendations from the grand jury and the board of supervisors.

Although the county hospital ordinarily accepts only charitable cases, persons who are able to pay for hospital care are accepted in the isolation ward if they are suffering from contagious diseases, or are injured in an accident and require emergency treatment. Other hospitals are not equipped to handle contagious diseases.

County Auditor Vincent L. Roth, made a special check of the records of the isolation ward and emergency cases, and his report to the board showed that 972 cases

were handled in the hospital in the two classifications between last July 1 and Sept. 28.

Of these, Mr. Roth said, 485 were charity cases and 478 cases were those of patients able to pay for their care. In this latter group, 83 persons have paid their accounts in full. Mr. Roth said letters requesting payment were issued to the remaining 404 persons and to date, 59 said they would pay their bills. Of the 59, said the auditor, 17 have made partial or full payment. The auditor's letters were not acknowledged by 231 persons while the correct addresses of 83 have not been found.

There were 31 persons who have bills for ambulance service, but these are not proper hospital charges but are payable to mortuaries and persons operating ambulance service, said Mr. Roth.

Under the new system installed in the hospital, as soon as possible after the entrance of a patient in the hospital in either the emergency division or isolation ward, a social service worker shall establish the hospital treatment.

Rubbing Alcohol Priorities

Copy of a Resolution approved by the Executive Committee of the California Medical Association, at its meeting of December 13, 1942, follows:

WHEREAS, The use of rubbing alcohol for local use in cleansing and protective purposes on the skin of patients is an accepted part of hospital procedures; and

WHEREAS, It would appear that many of the smaller hospitals located in California (according to a recent ruling of the governmental authorities through directive W.P.B.—M-30, with respect to the use of ethyl alcohol and related compounds), will be deprived of the right to secure an adequate amount of rubbing alcohol, in like manner as that right is given to certain larger hospitals and to members of the medical, dental and veterinary professions and certain governmental agencies; and

WHEREAS, Under existing war conditions, because of which the number of nursing and other aide personnel who look after patients is considerably diminished, so that it is no longer possible in many institutions to give the same amount of soap and water bathing and similar care to patients (a considerable number of whom may be citizens brought in from essential industry plants); and

WHEREAS, The order as it now exists would seemingly work, not for the fullest protection of the public health or of workers in essential industries, but rather to the detriment of such, who may come under care in a goodly number of smaller hospitals in California; now, therefore, be it

Resolved, By the California Medical Association, through its Executive Committee, that the request of the Association of California Hospitals for a modification of the orders having to do with this problem be endorsed; and that the California Medical Association, representing more than seven thousand licensed physicians, many of whom are in military service, hopes that the necessary directives will be issued by which the best interests of the public health, insofar as hospital care is concerned, shall be conserved, through modification of the order referred to above.

Charitable Hospital Not Employer, Ruling

Los Angeles, Dec. 17.—(AP.)—A charitable hospital is not an employer within the meaning of the California unemployment insurance act, and therefore need not contribute to the State insurance fund on behalf of its employees.

Superior Judge Emmett H. Wilson so ruled in a suit brought by Seaside Hospital, Long Beach, against the State insurance fund. The hospital contended it accepts all patients, regardless of ability to pay, and that all members of the County Medical Association are eligible for membership on the hospital staff.—Oakland *Tribune*, December 17.

Free Clinic Hospital to Help Tubercular Patients Provided for in Charles Hastings Will

Research Center to Be Supported by $3,000,000 to $4,000,000 Endowment Fund; Institution to Rise Near Pasadena and Be Known as 'The Charles Cook Hastings Home'

Creation of a clinic hospital, a free research center for the treatment of tubercular patients and supported by a $3,000,000 to $4,000,000 endowment fund, has been made possible by the late Charles H. Hastings, owner of the famous Hastings Ranch, northeast of Pasadena, as revealed by his will, filed here yesterday for Commander Ernest Crawford May, by Cruickshank, Brooke & Dunlap, his attorneys. The will was submitted to probate about a fortnight ago in the Surrogate's Court of New York County, New York, where Mr. Hastings died domiciled, after a delay of approximately 10 months during which time extensive negotiations were conducted and successfully concluded with the heirs of Mr. Hastings, who were four cousins, all of advanced age and who had through their legal representatives filed a contest to the will. . . .

The clinic hospital, to be known as "The Charles Cook Hastings Home," in memory of his California-pioneer father who died of tuberculosis in 1890, ultimately will rise near Pasadena. . . .

While the will explicitly defines the objectives of the clinic hospital, all details such as size, location, operation and possible additional fields of medical research are left in the hands of the Hastings Foundation, incorporation papers for which will be filed promptly in Sacramento as directed in the will. The board of directors of this foundation is given the widest latitude in attaining Mr. Hasting's objectives.

Free Treatment

In his will he wrote:

"I have long contemplated organizing a nonsectarian charitable corporation under the name of 'The Hastings Foundation' for the study, prevention, treatment and cure of tuberculosis. . . . Such corporation shall have power to erect, equip and maintain a sanitarium . . . and it shall be conducted and maintained on a strictly charitable basis and no charge shall be made to patients therein, or for any treatment or other aid rendered thereby. Such corporation shall also be authorized to undertake the study, prevention, treatment and cure of other diseases, so that if at some future time said board determines that it is advisable to use its facilities, in whole or in part, in order to combat some other disease or diseases, it would have power to do so." . . .

In the incorporation papers, Commander May, Dr. Leroy B. Sherry and Lloyd W. Brooke appear as the foundation's original board of directors, additional members to be elected by the board as needs indicate. . . . —Pasadena *Post*, January 1.

Army, Navy, industry, public health—all must fight together and against tuberculosis.—Charles E. Lyght, M. D., *Amer. Rev. of Tuber.*, Sept., 1942.

Cow's milk contains three to four times as much calcium as human milk.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (22)

San Francisco County (16)

Grace Gunn Binger, *San Francisco*
Louis Sanders Constine, Jr., *San Francisco*
Morris E. Dailey, *San Francisco*
James R. Drake, *San Francisco*
Karl B. Eichorn, *San Francisco*
Ruth Fleming, *San Francisco*
Don G. Gardner, *San Francisco*
John Jay Hawthorne, *San Francisco*
William H. Ice, *San Francisco*
William Cortlett Keig, *San Francisco*
Hans Rathmann, *San Francisco*
Mary Mable Schmeckebier, *San Francisco*
Frederic Porter Shidler, *San Francisco*
Marion Alan Swanson, *San Francisco*
Nicholas Tesauro, *San Francisco*
William B. Wallace, *San Francisco*

San Luis Obispo County (1)

Harrison Eilers, *San Luis Obispo*

Santa Clara County (3)

Ann Franklin Barnett, *Palo Alto*
Robert Allen Lochr, *San Jose*
R. P. Quirmbach, *Agnew*

Solano County (1)

John Neal Clark, *Fairfield*

Transfers (1)

Lester S. McLean, from *San Bernardino County* to *Solano County*

In Memoriam

Crum, Howard Charles. Died at Santa Cruz, July 29, 1942, age 58. Graduate of Chicago College of Medicine and Surgery, Illinois, 1910. Licensed in California in 1915. Doctor Crum was a member of the Santa Cruz County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Graham, Rossner Enders. Died at Oakland, October 6, 1942, age 55. Graduate of Tulane University of Louisiana School of Medicine, New Orleans, 1914. Licensed in California in 1922. Doctor Graham was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Hall, Channing. Died at Alameda, December 14, 1942, age 57. Graduate of Cooper Medical College, San Francisco, 1911. Licensed in California in 1911. Doctor Hall was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Harris, Wayne Adelbert. Died at Santa Ana, November 25, 1942, age 62. Graduate of the University of Illinois College of Medicine, Chicago, 1904. Licensed in California in 1927. Doctor Harris was a member of the Orange County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Lane, John Alexander. Died at Eureka, November 13, 1942, age 69. Graduate of Cooper Medical College, San Francisco, 1898. Licensed in California in 1899. Doctor Lane was a member of the Humboldt County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Porter, Ernest Boring. Died at Altadena, November 16, 1942, age 47. Graduate of Northwestern University Medical School, Chicago, 1925. Licensed in California in 1925. Doctor Porter was a retired member of the San Diego County Medical Society, and the California Medical Association.

✤

Sawyer, Edmund Houghton. Died at San Francisco, November 17, 1942, age 61. Graduate of Harvard University Medical School, Boston, 1908. Licensed in California in 1909. Doctor Sawyer was a member of the Mendocino-Lake County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Spalding, Alfred Baker. Died at San Francisco, November 25, 1942, age 68. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1900. Licensed in California in 1902. Doctor Spalding was a retired member of the San Francisco County Medical Society, and the California Medical Association.

✤

OBITUARY

Frank E. Detling

1876—1942

Frank E. Detling was born May 23, 1875, at Plymouth, Wisconsin, the son of Val and Anna Marie Detling. He was educated in the public schools of Plymouth, and attended the Northwestern University Medical School, from which he was graduated in 1901. He served his internship at St. Mary's Hospital in Duluth, Minnesota, and his record at this hospital was so excellent that the Attending Staff requested him to open an office in Duluth, which he did and there practiced for several years.

Early in his career he decided to specialize in diseases of the eye, ear, nose and throat, and devoted all of his spare time to that study. In 1908, for several months, he attended the clinics of New York. He was Resident of the Wills Eye Hospital of Philadelphia from 1908 to 1909. About this time Dr. Robert W. Miller of Los Angeles, wrote to the Wills Eye Hospital for an Associate in his practice. Dr. Detling was highly recommended and after finishing his residency and visiting other Eastern clinics, he came to Los Angeles in 1910, to become associated with Dr. Robert W. Miller. One year later he was married to Betty G. Walsh at Superior, Wisconsin. Following his association with Doctor Miller for three years, he opened his own office.

Soon after his arrival in Los Angeles, Doctor Detling was appointed Instructor in Otolaryngology in the University of California Medical School and Otolaryngologist to the Graves Dispensary. He was later appointed to the Staff of the Children's Hospital, where he remained as Attending and Consulting Otolaryngologist until his death. For some twenty-five years he was one of the Senior Otolaryngologists to the Los Angeles County General Hospital. He developed one of the out-

† For roster of officers of component county medical societies, see page 4 in front advertising section.

standing departments of the hospital and devoted a great deal of time and energy to this institution.

Later, when the School of Medicine of the University of Southern California was organized, Dr. Detling was one of the first to be enrolled on the Staff as Associate Clinical Professor of Otolaryngology. He had much to do with the organization of the clinical teaching of the school. He devoted a great deal of time to duties at the Children's and County Hospitals and the School of Medicine, and often said that his happiest moments in practice were those spent in attending to these duties. He devoted his life to his profession and in doing so was very happy.

Doctor Detling was a Past-President of the local Eye and Ear Society, and Chairman of the Eye and Ear Section of the State Society. He always took an active interest in medical society work. His discussions were to the point. He was a most lovable character and no one in the profession commanded more respect for his knowledge and sincerity.

He was devoted to his family. He leaves a wife, Betty, a son, Val, and two brothers in Wisconsin.

J. M. BROWN,
S. JESBERG.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

County Auxiliary News Items

The Woman's Auxiliary to the Los Angeles County Medical Association held its November meeting, at 12:30, on Tuesday, November 24, at the Los Angeles Athletic Club. There were eighty-four members and guests present.

Miss Eleanor King, author, columnist, and radio artist, gave an interesting and enlightening talk on "Charm." She stressed the fact that health and good posture are important factors in being a person of charm.

Guests of honor were Dr. Vincent Askey, Chairman of the Board of Trustees of the Board of Education; Dr. C. Morley Sellery, Director of Health Service, Los Angeles City Schools, and officers of the first and tenth districts of the Parent-Teachers Association. Hostesses for the day included Mrs. Raphael Dunlevy, Chairman; Mrs. Philip Stephens, and Mrs. Paul Dougherty.

Mrs. Donald Charnock, War Activities Chairman, announced that Tuesday, December 15, would be the Auxiliary's Day at the Red Cross Blood Bank. She and her committee are working diligently to make this a success.

Members of the Riverside County Medical Auxiliary met at the home of Mrs. H. W. Naeckel for their annual benefit bridge party. Funds from this benefit are to be used for subscriptions to *Hygeia*, to be placed in schools and other public places. Mrs. Ralph Smith was Chairman. During the tea hour, Mrs. George Rue entertained with piano selections.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

The December meeting of the Woman's Auxiliary to the Marin County Medical Society was held at the Blue Rock Hotel, in Larkspur, on Thursday evening, December 3. The president, Mrs. Rodney Hartman, presided.

A short business meeting followed. It was decided to have, in the near future, individual bridge parties put on by members, to raise money for the treasury.

An extremely enjoyable talk was made by the guest speaker of the evening, Mrs. Roy Nisja, who is a well-known Marin County nutritionist and instructor at the Marin Junior College. Her talk on nutrition was instructive, and made more interesting by colored charts which brought out the rapidly-changing food picture.

Dr. Clifford Kuh, Chief of the State Bureau of Public Health, addressed the Woman's Auxiliary to the San Francisco County Medical Society at their regular meeting on the 17th of November. Dr. Kuh's subject, interesting and timely, was "Health Problems Raised by the Employment of Women in War Industry."

Tea was served to about fifty members and guests. Mrs. Norman Morgan, Hospitality Chairman, was assisted by Mrs. Roger McKenzie and Mrs. J. C. Long.

Members of the Auxiliary were hostesses at the Hospitality House on December 4, 1942, for the second consecutive year. Mrs. Roger McKenzie, Chairman, and Mrs. Norman Morgan, Co-Chairman, assisted by a splendid committee, planned a very entertaining day for the boys in the armed forces. Mrs. William Reilly, Mrs. Edmund Morrissey and Mrs. Raleigh Burlingame were hostesses.

The Woman's Auxiliary to the Fresno County Medical Society enjoyed the company of Mrs. Lindemulder at the November luncheon, held in the University-Sequoia Club. Mrs. R. W. Dahlgren, President of the Fresno group, presided and introduced Mrs. Lindemulder to the members and guests, who included several of the wives of medical officers stationed at Hammer Field. It was an interesting meeting, for, after a brief talk, Mrs. Lindemulder invited an informal discussion on matters pertaining to Auxiliary work.

Miss Maude Schaeffer, who recently returned from Honolulu, was guest speaker at the December meeting. She talked on the conditions in Honolulu before and after December 7.

It was decided to furnish a recreation room for the use of the bachelor doctors on duty at Hammer Field. Mrs. J. R. Walker will take charge of this project.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (October)		35,000
Rural Health Program		3,500
War Housing Projects (January 1st)		
(Approximate)		31,800
Vallejo	10,000	
Marin	5,000	
Los Angeles	6,800	
San Diego	10,000	

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

The year 1942, as was expected, was a difficult one. The rapid turnover in employment caused by the change-over to a war economy resulted in a serious loss of membership. New business to offset this loss was difficult to obtain for the same reason. Despite these difficulties, C.P.S. was able to maintain an average membership of 38,000 to 40,000 throughout the year.

C.P.S. has also undertaken an important change in its basic contract—from the old "Full Coverage" to the "Two Visit Deductible" and "Surgical" plans. These new contracts are designed to bring the unit value up to par, and the process of conversion is well under way.

The true value of C.P.S. has become apparent in the last year. When Federal Agencies were confronted with the problem of securing medical care for transient war workers, it is interesting to note that these Federal Agencies singled out C.P.S. as the only medical care organization in the United States with which it could work out these problems, and the only doctor-owned agency that was ready and able to meet the need.

Medical Service Plans Discussed at Annual Session of State Medical Association Secretaries and Editors at A.M.A. Headquarters

The Journal of the American Medical Association printed the addresses and discussions on medical service plans, medical licensure and kindred topics in two recent issues (December 12, pp. 1244-1235, and December 19, pp. 1315-1324). Numerous references were made to California plans. Comments by Doctor George H. Kress, Secretary of California Medical Association, appeared on pages 1232. 1233 and 1322. To the credit of the California Medical Association, it may be said that no State medical association can show a broader approach to the issues involved in medical service plans: Agricultural Workers Health Care; Federal Housing; Federal Social Security for Rural Farm Families; and Statewide coverage offered by California Physicians' Service. C.M.A. members will find many items of interest in the addresses and discussions presented at the recent Conference of Secretaries and Editors.

Unusual Medical Plan Is Used By Housing Tenants

Chicago, Dec. 7.—(CCNS.)—Families at the Marin City, Calif., war housing development, are financing their medical care on a prepay plan through a tenants' mutual health association, according to the National Association of Housing Officials.

Complete medical care, surgery and hospitalization are furnished under the plan by agreement with the California Physicians' Service, a nonprofit organization which operates a Statewide prepayment medical service. Fees are $5 a month for a family with children, $4 for a two-person family, and $2.50 for a single person.

A medical center is set up in the housing project, supplied with equipment and staffed by nurses and one resident physician for each 1,500 persons.—Los Angeles *Greater Los Angeles*, December 11.

Workers Meet Health Costs With Rentals

Persons in Housing Projects Pay Insurance in Advance, Doctors' Group Reveals

San Francisco, Dec. 10.—(AP.)—Health insurance paid in advance as part of the rent is already in effect for 8,000 California war workers in federal war housing projects, and soon will spread to 100,000 more, officials of the California Physicians' Service disclosed today.

Dr. A. E. Larsen, medical director of the doctors' organization, said the program took root among San Diego airplane workers last May and now includes Marin County with its new Bechtel Shipyard and Hamilton Field, Los Angeles, with its airplane plants and shipyards and the vast Vallejo shipbuilding area.

They All Agree

In each case, Dr. Larsen said, local physicians' groups, the C.P.S., the federal public housing authority and the local housing authority came to complete agreement on the matter.

The cost of protection, available only to those living in war housing projects, is $2.50 a month for a single worker, $4 for a man and his wife and $5 for a man, wife and family.

Patients with minor illnesses are treated in the clinic provided at each housing project. If their illness is serious, they are advised to consult a private doctor of their own choice, the bills being paid out of the accumulated pool.

Dr. Larsen said many doctors have been brought from towns left nearly depleted by the exodus to war plants, and alien physicians, unable to obtain commissions in the army or navy, have been given jobs caring for war workers.

"This is not State medicine," he said, "but it merely shows that the medical profession has found a way of working with the government."—San Bernardino *Sun*, December 12.

Physicians Get Prepaid System Extended Here

San Diego, Calif.—A new medical plan for war workers is being launched in West Coast housing projects by the California Physicians' Service, in agreement with the Federal Housing Authority. The plan is already in operation at the Linda Vista project, near here.

The plan provides full medical care, including hospitalization, at monthly rates of $2.50 for a single man, $4.50 for a couple and $5 for a family with children.

A medical center staffed by resident physicians and nurses is built at each project covered by the plan.

The C.P.S., sponsored by the California State Medical Association, was organized four years ago as a Statewide prepayment medical service. Despite suspicion that the organization was started to head off a strong movement for State-operated health insurance, the present plan has been approved by union representatives and physicians who favor group medicine.—Richmond *Labor Journal*, December 11.

Paying the Doctor in Advance

Doctors have many bills on their books that will never be paid, but out in California the story is a lot different. There several thousand families in California's war-plant industrial communities pay their doctor in advance just the way they pay their rent. And, in a few weeks, 35,000 of California's farm families will be using a similar pay-in-advance plan for their physicians.

Besides insuring that the doctor gets what is coming to him the plan has definite advantages to the patient in that medical care costs a lot less in this way.

In cities where the idea is in force, the money paid for medical care goes to the Housing Authority which turns it over to the California Physicians' Service which assigns doctors and nurses to the sick and maintains clinics.

The plan for farm folks, as announced by the Farm Security Administration and the California Physicians' Service, allows about 130,000 persons, members of the 35,000 families, to join if the family's net yearly income is $2,000 or less. Last year, in three experimental counties, this care cost between $10 and $20 per person a year.—Los Angeles *Examiner*, December 6.

Applications Are Being Received in Health Association

Applications are now being received for membership in the Farmers' Health Association which is being formed throughout Merced County to help the farmers meet the high cost of illness and accidents.

Any farmer or farm laborer is eligible to join if he receives more than one-half his living from the farm and had not more than $2,000 net income in 1941. The cost is $20.50 per person with $60.50 the most that even the largest family pays for a year. All the necessary medical, hospital and surgical care for children under nineteen, maternity care, and treatment of acute illnesses and accidents for adults are furnished for this fee which is paid in advance. Hospitalization is allowed up to 21 days for each separate illness.

Of the 5,000 doctors who belong to the California Physicians' Service, any one may be chosen for the family doctor. All licensed doctors of medicine are eligible for membership in the California Physicians' Service.

For further information, call Merced 1405. Application blanks may be obtained from Mrs. Catherine C. Simson, Secretary of the Organizing Committee, 105 Business and Professional Building, Merced, California.

It is necessary that all applications and money orders or checks made payable to California Physicians' Service be in by December 10, so service may begin early in January.—Merced *Sun-Star*, December 10.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles, on Sunday, May 2—Monday, May 3, 1942.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

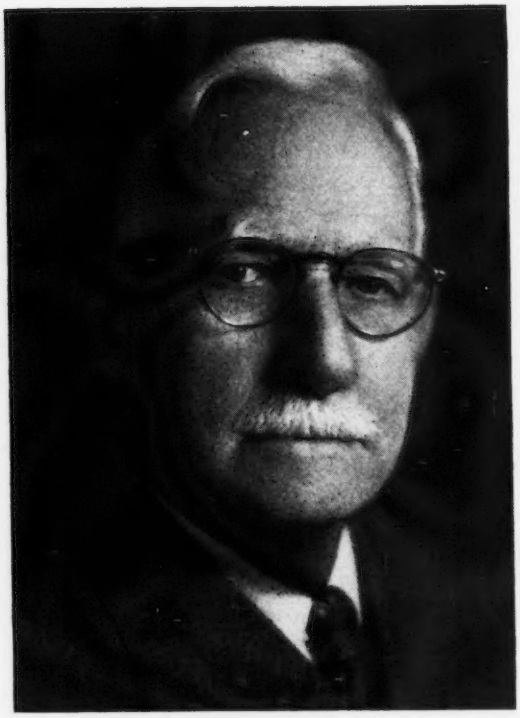
KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In January KFAC will present these broadcasts on the following Saturdays: January 2, 9, 16, 23, and 30.

The Saturday broadcasts of KECA are given at 10:30 a. m., under the title "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.



John C. King, M. D., President of the California Medical Association in 1910, who will attain his 90th Birthday on February 9, 1943.

It is a pleasure to bring to the readers of CALIFORNIA AND WESTERN MEDICINE word of one of our oldest State Association Presidents, Doctor John C. King of Pasadena, who, on February 9, 1943, will celebrate his 90th birthday. After a long life of great usefulness, Doctor King is still alert, mentally and physically; and although he has withdrawn from active participation in professional interests, he is down-to-date on the proceedings of medical organizations, and keeps well informed regarding new discoveries and advances in medicine and surgery.

Doctor King was born in Pittsburgh, Pennsylvania, February 9, 1853. He was educated at Newell Institute, and received his M. D. degree at the University of Nashville in 1874. He served as an intern in Pittsburgh Hospital where he was on the Dispensary staff. Upon coming to California, he at once began an active interest in medical and civic affairs. He was president of a high school board for 20 years; he helped to organize the San Bernardino County Medical Society, and became its president; he was also president of the Riverside County Medical Society, and later president of the Southern California Medical Society, and in 1910 he was elected

president of the California Medical Association.* In 1923 he retired from the practice of medicine in Banning, where he specialized in tuberculosis, and removed to Pasadena.

In addition to his active professional life, Doctor King has been an earnest student of the Bible, and for sixty-five years has given continuous service to both church and Sunday Schools, as either superintendent or teacher. On December 27th, he brought to a close this phase of his activity, and on that afternoon hundreds of his friends gathered at his home in Pasadena to do him honor.

Since retiring from active practice 20 years ago, Doctor King has engaged in the delightful hobby of cultivating fine flowers, devoting himself in his large garden, especially to choice roses and magnificent dahlias, which he has generously sent to hospitals and churches. He has done, and still does, the major part of the gardening, himself—eating his simple breakfast at seven o'clock, working through the early morning, and then resting and reading through the remainder of the day.

Because of his successful practice, and his noble life, Doctor King is held in highest esteem by the profession, and in truest affection by his numberless friends.

The members of the California Medical Association extend to him, all good wishes.

Pharmacological Items of Potential Interest to Clinicians:**

1. *Lots More New Books:* Galveston Orchids (Oleanders), to L. Untermeyer for his fine anthology of British and North-American poetry, including M. Moore's but not Wm. Ellery Leonard's, Ralph L. Woods' "Treasury of the Familiar" (MacMillan, 1942), is also well designed for the average North-American. Tops in autobiography is L. P. Jacks' philosophical "Confession of an Octogenarian" (MacMillan, 1942). C. M. Wilson's "Ambassadors in White" (The Story of American Tropical Medicine, Holt, 1942), is the usual superficial journalist's account derived from the obvious sources. Edgar Erskine Hume's "Ornithologists of the U. S. Army Medical Corps" (Hopkins, Baltimore, 1942), is a charming 580-page tome covering 36 biographical sketches in the best Humian style and you'll be surprised that Sternberg, Munson, and Leonard Wood were ornithologists, as well as the great Casey Wood. W. J. S. Krieg's "Functional Neuroanatomy" (Blakiston, Phila., 1942), is an artistic triumph, initials and all. A helpful volume is G. W. Corner's "The Hormones and Human Reproduction" (Princeton, 1942). It's pleasing to see A. J. Quick's scholarly and practical "Hemorrhagic Diseases and Physiology of Hemostasis" (C. C. Thomas, Springfield, 1942). V. H. Moon discusses *Shock: Its Dynamics, Occurrence and Management* (Lea and Febiger, Phila., 1942). Then there's *The Time of My Life*, by H. C. DeVighne, Alaska's frontier doc (Lippincott, 1942). And P. A. Sorokin's *The Crisis of Our Age* (Dutton, N. Y., 1942). As well as R. West's *Conscience and Society* (Methuen, Lond., 1942). In addition to H. Trevelyan's *Gothe and the Greeks* (Cambridge, 1942), and M. Rostovtzeff's 2 vol. *Social and Economic History of the Hellenistic World* (Oxford, 1942)—in contrast to J. Needham and J. S. Davies' *Science in Soviet Russia* (Watts, Lond., 1942), for forty cents.

2. *On Burns:* C. K. Drinker & Co. (Surg., 12:685, 1942), begin series of studies on lymph flow from burned tissues. Ralph Pendleton's Open-Air Paraffin Wax Spray Treatment is succinctly described in a 4-page folder listing 14 advantages, with details and illustrations. Write for copy to U. S. Naval Hosp., Mare Island, California.

3. *Renin:* October issue *Amer. J. Physiol.* gives practical symposium: G. E. Wakerlin & Co. find little prophylactic value in experimental renal hypertension; E. Ogden & Co. find renin does not pass the placenta and that fetus is much less responsive than mother; while M. Friedman & Co. note that daily injections aren't much use in hypertensive dogs (137:515; 473 and 570, 1942).

4. *Transfusion Data:* A. Bagdasarov (Central Blood Inst., Moscow), describes Russian transfusion methods (*Brit. Med. J.*, 2:445, Oct. 17, 1942). J. Beattie (*Lancet*, 2:445, Oct. 17, 1942 ref. O.K.!), in describing fate of transfused plasma, notes rapid loss of fluid and protein from circulation after transfusion. H. A. Davis and G. R. Meneely (*Science*, 96:468, Nov. 20, 1942), in discussing probability of obtaining potentially dangerous pools of human serum or plasma, suggest using large number of components and estimating iso-agglutinin titer to reduce risk.

5. *Infections:* T. J. Mackie (*Edin. Med. J.*, 49:607, 1942), neatly reviews the problem of those that may be air-borne. O. H. Robertson & Co. (*J. Exper. Med.*, 75:593, 1942), show propylene glycol spray (1 gm./2000 liters of air), is effective air disinfectant, and of course nontoxic.

6. *Wind-Ups:* H. O. Calvery's swell review (*Amer. J. Pharm.*, 114:324, 1942), of food, drug, and cosmetic coal-tar colors gives name and formulae of certified ones Have you spotted the resurgence of the *Chemical Warfare Bulletin*, now in its 28th vol.? A. J. Henry and D. N. Grindley (Khartoum), in describing method of estimating stilbamidine in biological fluids (*Ann. Trop. Med. Parasit.*, 36:102, 1942), note its absorption on blood corpuscles. C. C. Ungley and W. Blackwood (*Lancet*, 2:447, Oct. 17, 1942), discuss immersion foot peripheral vasoneuropathy after chilling. The Nov. issue *Canad. Med. Asso. J.* is the Banting Memorial Number and is notable for illustrating his oils, unfortunately not in color, Best and Collip's historical articles, M. M. Hoffman's note on metabolism of progesterone, and K. C. Fisher's discussion of narcosis which reaches conclusions like those of Loevenhart's (*J. Pharmacol. Exper. Therap.*, 5:239, 1914; *Arch. Int. Med.*, 15:1059, 1915).

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in CALIFORNIA AND WESTERN MEDICINE (July issue, pages 108-109; October, pp. 269-270; and November, pp. 287

---

* The living ex-presidents of the California Medical Association with years of their administration, include: George H. Evans, San Francisco, in 1907; John C. King, Pasadena, in 1910; O. D. Hamlin, Oakland, in 1912; George H. Kress, San Francisco, in 1916; John H. Graves, San Francisco, in 1921; Edward N. Ewer, Oakland, in 1925; William H. Kiger, Los Angeles, in 1928; Morton R. Gibbons, San Francisco, in 1929; Lyell C. Kinney, San Diego, in 1930; Junius B. Harris, Sacramento, in 1931; George G. Reinle, Oakland, in 1933; Clarence G. Toland, Los Angeles, in 1934; Robert A. Peers, Colfax, in 1935; Edward M. Pallette, Los Angeles, in 1936; William W. Roblee, Riverside, in 1938; Harry H. Wilson, Los Angeles, in 1940; Henry S. Rogers, Petaluma, in 1941.

** These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

and 331-332. Some recent excerpts follow:

* * *

Keep It That Way

Many members of the medical profession are going into military service every day. Young doctors just out of medical school, doctors who have barely established themselves in the community, and long-established men who would soon begin to shift the burden of their practice to new partners, are donning uniforms. For the medical men remaining at home, the task will be gigantic. But one and all they are grimly determined that essential medical care will be provided to civilians.

There are many ways in which the layman can help in this medical crisis. He can guard his own physical wellbeing by keeping regular hours and eating and sleeping properly. He can be tolerant if he is kept waiting for an appointment. And he should follow stringently the advice of his physician in order to return himself to full usefulness as soon as possible. These are the tangible ways in which the layman can help the doctor.

In addition, there is a vast intangible aid that we can give our medical men. We can keep in mind the fact that they are a part of the system of private medicine that has doubled the span of life for the ordinary citizen in a comparatively few years. The doctors in the armed forces, just as the ones staying at home, spent years in training and more years interning because competence and efficiency are the very foundation stones of our medical system. There is no taint of "ism" or politics in their blood. Let's keep it that way.—Willows *Journal*, November 27.

* * *

A Living Symbol

Families or parents who have men in military service have something to be thankful for that they probably do not fully appreciate as yet. Our military forces enjoy the most technically perfect, the most humane medical care ever conceived. The best men from the ranks of medicine are in uniform.

An incident that happened recently aboard a battleship "somewhere in the Pacific" may not prove unusual. An enlisted man was abruptly stricken with appendicitis. After a successful emergency operation in the ship's surgery, he found himself attended by his family doctor from his home town. A feeling of confidence and reassurance that flowed into the heart of the patient can well be imagined. Such incidents by repetition will become one of the biggest morale boosters both on the home front and the military front.

The doctor is a vital connecting link between the service men and the country for which they fight. He is a living symbol to the men at the front of the principles of integrity and decency that we are fighting to save.—Carlsbad *Current-Argus*, November 18.

* * *

Protecting Public Health

Civilian medical care in the face of a war born doctor shortage, is a problem. And the doctors, even more so than the civilians, know it. In the first place, the problem is not confined solely to a doctor shortage. There is a shortage of nurses, nurse's aids and labor in general in our hospitals, sanitariums, doctors' offices and all other institutions that help to maintain the physical well being of civilians.

The medical profession is working rapidly and in full coöperation with public and private health organizations to alleviate the situation. They are making definite progress. Additional beds are being installed in critical areas to care for the heavy influx of war workers; plans are being made for establishing hospital service and clinics staffed by doctors working in shifts; steps are being taken to ease the nurse shortage by cutting nonessential tasks of present nurses; and preventive measures, including sanitation, innoculation and isolation are being stepped up. And emergency facilities in event of unforseen disaster, are not being overlooked.

To bring medicine into politics would be disastrous. —Woodlake *Echo*, December 4.

* * *

Don't Shoot, Please

A Washington committee, fearful of a dangerous doctor shortage, has proposed arbitrary halting of further enlistment by medical men in the armed services until a bureau has been created to "supervise and control the drafting and recruiting of doctors." Apparently, pending establishment of the bureau, our soldiers are supposed to keep out of the way of enemy bullets.

The military services are entitled to every doctor they need. And they are entitled to them without awaiting the pleasure of a bureau in Washington. As the American Medical Journal observes: "The least that the nation can do for those who offer their lives in combat is to provide them with the utmost that medicine can offer for the alleviation of the wounded and the prevention of unnecessary death." The armed forces are getting the doctors they need. They are getting them now; the best medical men in the world.

As far as civilian needs are concerned, the American Medical Journal points out that a weekly survey by the Procurement and Assignment Service maintains a constant check on physicians in local communities. This service was created by the President of the United States. It works in close coöperation with the medical profession which does not propose to allow any lapse in the high and hard-won health standards of America.—Industrial *News Review*.—Cypress *Enterprise*, December 9.

* * *

Two Jobs

The action of the medical profession in voluntarily supplying the armed forces with practically the full quota of physicians requested for 1942, has proved that this country can still get a few things done without employment of legislative force. Ernest Lindley, Washington commentator, recently complimented the doctors on the success of their effort when he said: "A few months ago the prospective shortage of physicians in the Army was serious. The job of overcoming this was undertaken by the War Manpower Commission with the coöperation of the American Medical Association. . . . A roster of 176,000 licensed physicians was available from which to draw the military quota of 42,000 for 1942, while preserving as far as possible an even distribution of medical care for the civilian population. This recruitment is still in process. With the year almost three-fourths gone, five-sixths of the quota has been filled."

Actually the performance of medicine in meeting Army needs is not surprising, in view of the history of medical progress in the United States. The health record of our people shows that the medical men are in the habit of achieving results. Right now they are setting to work on the problem of civilian medical care. Unlike other civilian activities, medical care for those at home cannot be put on ice for the duration. Nothing could imperil the war effort more quickly than a breakdown in our health standards.

The doctors have two jobs—one civil, the other military. Both jobs must be done well, and will be under the initiative of the American medical system.—Oakland *Saturday Press*, December 5.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Southern California Medical Society

Aspects of the war as it affects people in Los Angeles will be given consideration at the 107th semiannual meeting of the Southern California Medical Association, which will open a two-day session tomorrow at the County Medical Association, 1925 Wilshire Boulevard.

Tomorrow's session will be devoted to a discussion of disorders of the foot.

"Gasoline rationing is going to cause nearly everyone to walk a great deal more than any of them have been accustomed to. Disorders of the foot will become problems for many thousands of people," Dr. Nelson Paul Anderson, secretary-treasurer, stated yesterday.

More than 600 members of the County Medical Association are now with the Medical Corps of the Armed Forces. Because of this the Saturday afternoon session will be devoted to a symposium on office procedure.

The new plan is designed to increase the efficiency of the doctor in the managing of his patients in his office so as to allow for the giving of medical care to more who need it.

The Saturday morning session will be given over to clinical papers.—Hollywood *Citizen-News*, December 10.

* ** *

Porter Clinic Trustees

Sacramento, Dec. 30.—(INS.)—Appointments, including members of the board of trustees of the Langley Porter Clinic at San Francisco, were made by Governor Olson today.

Appointed to the Langley Porter board of trustees, all to serve until December 23, 1946, were: Lawrence R. Jacobus, M. D., Oakland; and Doctors James F. Rinehart, Charles E. Smith, Karl F. Meyer, all of San Francisco, and Dr. Z. T. Malaby of Pasadena.—San Francisco *Call-Bulletin*, December 30.

* * *

New Transfusion Method Employs Thicker Plasma

Chicago (UP.)—A new method of blood transfusion promises more effective treatment for men wounded on the fighting fronts, the Journal of the American Medical Association said today.

The discovery that albumin in blood plasma (the liquid part) could be injected in more concentrated form than whole plasma provided "a new method of great effectiveness for combating shock from injuries, hemorrhage and burns."

The method was said to be particularly important for treating wounded on the battlefield to reduce the mortality from shock.

Doctors using the albumin serum would need it in quantities only one-fifth as large as those required if whole plasma were used, the Journal said.

Hence its use would facilitate shipping storage and administration.—Burbank *Review*, November 28.

* * *

Medicine Man Knew About Fever Therapy

Los Angeles, Nov. 30.—Artificial fever as a cure for certain diseases is far from a new expedient, according to Dr. Arthur Patch McKinlay, at the Los Angeles campus of the University of California.

A cowboy taken with mountain fever was found in a dying condition by a Wyoming Indian medicine man. With a funnel and a bucket of hot water, repeated injections induced fever and finally the cowboy broke into a heavy perspiration. As the story was told to the professor, this happened about sixty years ago.

In San Quentin in 1926 and 1927, malaria protozoans were given as a cure for paresis, as told by reports reaching Dr. Theodore D. Beckwith, chairman of the department of bacteriology at the University; and as long ago as 1915 in Portland, Oregon, a prominent druggist sold a heat-inducing machine intended to kill germs infecting certain areas of the body.—U. C. *Clip Sheet*.

* * *

Bogus Doctor Is Sentenced to U. S. Prison

Arthur Osborn Phillips, 48, bogus Chico doctor, today was sentenced to serve five years in a federal penitentiary following his plea of guilty to three to four counts charging him with falsifying government records in obtaining employment as a Civilian Conservation Corps physician.

The sentence was imposed by Federal Judge Martin I. Welsh. . . .

The prisoner recently completed a county jail term in Butte County for practicing medicine without a State license. . . .

Phillips admitted he served various penitentiary terms for violating medical practice laws. The terms included one year in Atlanta, Ga., on a narcotics charge.—Sacramento *Bee*, December 10.

* * *

Emergency Recruiting Nations' Death Knell

Los Angeles, Dec. 27.—Due to an unwise recruiting system, France had 1,040,000 fewer births between 1915 and 1919, and in 1940 found herself with 700,000 fewer men between the ages of 20 and 25 years.

This is pointed out by Dr. Constantine Panunzio, associate professor of sociology on the Los Angeles campus of the University of California. He adds that Germany, because of the first world war, had 2,900,000 fewer births, but its growing population rapidly made up the loss.

"England had a far-seeing policy," states Dr. Panunzio. Her recruiting made possible the maintenance of a relatively high birth rate. It deferred married men until the end of 1916, provided family allowances for men who married after enlistment, granted allowances to their wives for each child, and later made similar provisions for drafted married men.

"Consequently, while France lost 1,040,000 births, the United Kingdom, with a population greater by more than 4,000,000 persons, had only 650,000 less than it might have had. England was able to repair the loss. France was not.

"In former wars nations, considering only the emergency of the moment, drew upon all men of military age regardless of marital status and without considering the effect on future manpower."—U. C. *Clip Sheet*.

* * *

Substitute for Quinine Now in Mass Production

Atabrine, substitute for war-scarce quinine, is now being produced at the rate of about a half billion tablets per year. Actual production totals may fall somewhat short of this estimate, according to authorities here. Still there will be plenty of antimalarial units to treat millions of cases.

High speed laboratory machines are spewing tablets of the bright yellow crystals at an ever increasing rate—making bullets to attack malaria to which the armed forces are exposed.

With our men fighting in malaria infested tropics, antimalarial supplies are of vital importance. The periodic fever is not only a serious disease but could dangerously affect combat strength.

"We have four enemies," one military medical authority here declares, "Japan, Germany, Italy—and malaria. There is only one that can lick us. That's malaria. We've got to get results."

Stockpile Dwindles

Many Army doctors still prefer natural quinine, extracted from cinchona bark, to atabrine synthesized in the laboratory. But our dwindling stockpile of quinine was obtained mainly from Jap-held territory in the Far East. Atabrine relieves the shortage.

It should do the job just as effectively as quinine, it is reported by most investigators. There are fewer relapses of cases treated with atabrine, in fact, than when treated with quinine.

Atabrine also compares favorably with quinine in suppression of the disease, clinical reports show. Malarial parasites which hitch-hike from one soldier to another via the mosquito, are eliminated from the blood picture in about a week under either method of treatment.

Only about a fifth as much atabrine as quinine is required for an effective dose. This amounts to about a seventy-second of an ounce of atabrine per day.—*Science Service*.

* * *

Plague Cure Indicated

Yreka, Dec. 15.—Sulfadiazine may prove a definite aid in curing bubonic plague, it was indicated today by Doctors Albert E. Newton, Siskiyou County physician, and Karl F. Meyer, director of the Hooper Foundation for Medical Research at the University of California.

The sulfa drug is being used in the treatment of Donna Mae DeRose, daughter of Mr. and Mrs. Manuel F. DeRose of Hawkinsville, a ghost mining town near Yreka.

Admitted to the Siskiyou County General Hospital early in November, the child was examined by Dr. Newton, who diagnosed her illness as bubonic plague. After being consulted by long-distance telephone, Dr. Meyer confirmed the diagnosis and suggested a procedure for treating the case with large doses of sulfadiazine, while controlling the blood level.

"The purpose of this treatment," Dr. Newton indicated, "is chemically to inhibit the growth of bacteria in her body."

The drug acts to prevent multiplication of the plague bacilli, he explained, and thus aids in enabling white blood cells to combat the germs.

While the patient is greatly improved, her temperature fluctuates and she is not yet out of danger, Dr. Newton stated, adding that while he believes sulfadiazine definitely helped, it is too early to draw a final conclusion.

Siskiyou County had two bubonic plague deaths last year. These fatalities, as well as the present case, were contracted from fleas which had fed on infected rodents. —U. C. *Clip Sheet.*

* * *

Social Medicine

Editor the Chronicle—Sir: The Beveridge scheme for the social revolution of English life was ably handled by both Dorothy Thompson and Chester Rowell in your issue of December 5. I must, however, challenge Mr. Rowell's remarks about social medicine. He says: "There is no reason why it should apply to the self-supporting." There is a reason, and one that goes to the very root of this social revolution, which is coming, all right, both in England and the United States. Thank God, I say, for it. . . .

As medicine is now practiced, the very wealthy are the only people to get a square deal financially, although even they do not necessarily get a square deal as a whole. They have so much money that illness does not affect them financially to any great extent. The indigent get the same treatment from the same surgeons and the same hospitals, but it is flung at them as charity. The most unfortunate are the average people, who, being neither wealthy nor indigent, are bled white.

Now, if specialists and hospitals set their fees according to income, why cannot such fees be paid to them by the government out of a medical reserve built up through the medium of the income tax? Such a scheme, which is evidently what Sir William Beveridge has in mind, would give the specialists and hospitals exactly the same fees, and would spare the patients the frank questions they are asked about their finances at clinics—questions which are in order when put by their elected government, but when put by private persons are merely impertinent. Under this scheme, moreover, a surgeon would be compelled by the law to see a case through once he had operated.

Pacific Grove. J. A. STRAKER.

—From the "Safety Valve" department of the San Francisco *Chronicle,* December 9.

* * *

Medicos

Editor the Chronicle—Sir: A letter by J. A. Straker on social medicine in your paper exposes a total ignorance of the relations of a medico with his patients. If Mr. Straker could be in the office of one for a month he would learn how wrong his present ideas are. Moreover, he also exposes the very human desire to get something for nothing.

When a specialist acquires a great reputation patients flock to him, so that unless he does something time is too short to permit proper care. The something that he does is to raise his fees and so reduce the number of patients. He takes the same way out as did a famous Philadelphia surgeon whose minimum fee for any operation was $1000. When people objected he said there were hundreds of men in the city who could do the operation just as well as he at a fraction of his fee.

The same with other specialists. Just because they happen to have a reputation doesn't mean that they can take care of patients any better. Sometimes undue reputations are directly due to a flair for publicity and the ability to put on a good act. As a general rule, a patient stands a better chance in an office that is not too crowded as a result of "reputation." Whenever I hear a man say that he "sees" 130 patients a day I know that the word "see" is right.

Mr. Straker doesn't know about the large number of dead beats who refuse to pay after receiving service. The honest suffer for the misdeeds of the dead beat.

Oakland. RODERIC O'CONNOR.

—A Reply in the "Safety Valve" department of the San Francisco *Chronicle,* December 21.

* * *

Dr. Pryor Urges Prenatal and Child Clinics

Prenatal and child welfare clinics are urgently needed in every town, especially in defense areas, if scientific advancements of the past quarter century in the field of immunization, control of communicable disease, better understanding of nutrition and child psychology are to be made available to the mothers of the coming generation, according to Dr. Helen Pryor, medical adviser for women at Stanford University, who spoke at McKinley School auditorium yesterday on the wartime health lecture series.

Dr. Pryor called attention to the fact that there are 73,000 children stillborn every year in this country—tragedies caused by ignorance on the part of the mothers, preventable diseases and other reasons that might have been prevented by proper prenatal instruction, followed by adequate care of the child.

"If our country is to survive, immediate steps must be taken to provide proper education and care for the young mothers and children of today," said Dr. Pryor.

"Italy offers bonuses for large families and Germany condones illegitimacy, in order to increase the population. While this nation will not emulate these examples, it can do much to improve and increase the race by providing proper care and environment for the expectant mother and her child."

The speaker also described the procedure followed in immunizing infants against whooping cough, diphtheria and smallpox, and declared that nutrition is the most exciting new field of medicine.

Mrs. John J. Garland of Menlo Park, vice-president of the California Congress of Parents and Teachers, spoke on the new war problem, care of the children of war working mothers.

She supported Dr. Pryor's recommendation for the establishment of prenatal and preschool clinics and the education of mothers in proper health supervision of their families—provisions against the time when physicians' service may be unobtainable because of other war needs.

Dr. Ann Aller of Los Altos, instructor in adult education, concluded the panel discussion with a short talk on nutrition.—Redwood City *Tribune.*

* * *

Life Span to Be Stretched to Three Score and Fifteen

The life span probably will be stretched from the present 65 years to 75 years "in our time," said Morris Fishbein, editor of the Journal of the American Medical Association.

Writing in the A.M.A. publication, "Hygeia," Fishbein asserts an increased dissemination of already available medical knowledge is needed to extend the life expectancy of more people to 75 years.

"Most important in prolonging life after 50," he says, "are sound rules of diet and personal hygiene and suitable attention to the detection of degenerative diseases at the earliest possible moment.

"A new specialty is growing in medical science called geriatrics, which means the care of the aged. More and more physicians will become interested in gerontology, a study of the problems of the aged."—San Diego *Tribune-Sun.*

* * *

Native Shack U. S. Hospital

Doctors Operate Under Fire Near Battleline at Gona and Buna

Somewhere in a New Guinea camp.—Nov. 27.—In the jungle clearing a short way behind the Gona-Buna front there stands a crude hut which New Guinea natives built of kunai grass.

Toward that hut comes a steady stream of natives bearing wounded soldiers. They are covered with mud to the waist from ploughing through swampy jungle paths.

The wounded men are Americans and Australians. All day long those natives come in a steady stream. More come through the night, the moonlight glistening on their wet bodies.

Inside the hut there is a crude operating table which the natives built. Beside the table, stripped to the waist, stand Capts. Dr. Charles Lawrence, Chicago, and Dr. Felix Schwartz of Colorado. They operate for hours on Australians and Americans.

By torchlight and to the tune of mortar shelling and the sharp whine of American Brownings and the deep-throated howl of Australian machine guns they wield their scalpels.

They work with deft hands and sure and steady nerves, disregarding their own danger to minister to the wounded. They work swiftly. When one job is finished the patient is removed to make room for another.

Repeatedly the boys ask that some pal be treated first.

The soldiers and doctors continually give a remarkable demonstration of unselfish courage.—San Francisco *Examiner,* December 7.

The muscles of a human being account for 40 per cent of his body weight.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Statute of Limitations in Malpractice Actions: Time Within Which Suit Must Be Brought to Recover for the Negligent Leaving of Foreign Matter in a Patient's Body

It is a general rule that a court action by a patient against a physician and surgeon for injuries sustained by reason of the negligent or unskillful treatment administered by the physician is an action sounding in tort and is not based upon the contractual relationship existing between physician and patient. This being so, ordinarily, as in the case of other torts, an action for malpractice is barred under the provisions of Section 340 of the Code of Civil Procedure within the relatively short period expiring one year after the date of the injury. There are, however, recognized exceptions to this rule which, under certain circumstances, extend the time within which an action may be commenced. The courts have been particularly liberal in allowing a patient to prosecute a suit more than one year after the inception of the alleged injury in cases where the physician or surgeon has negligently left some foreign matter, such as a surgical sponge or skin clip, in the patient's body. (See Medical Jurisprudence articles in CALIFORNIA AND WESTERN MEDICINE, March, 1937, and February, 1939, on this same subject.)

It has been held where some such foreign object is allowed to remain within the body after an operation, that the failure to remove is the negligent act which warrants a malpractice action, that the obligation to remove is a continuing obligation and that the negligence does not terminate until the article is in fact removed. Each days' failure to remove gives rise to a new cause of action. On this theory, it is then determined that the statute of limitations does not begin to run from the date of the operation and an action for malpractice is not barred at the expiration of one year from the date of the operation. Again, in the case of *Trombley v. Kolts,* 29 Cal. App. (2d) 699, the court further extended the time within which a patient may sue in such cases by holding that where the relationship of physician and patient continued after the discovery of a skin clip left within the patient's body and where the physician advised the patient that no harm would result from allowing it to remain, the statute of limitations had not run and an action by the patient was not barred even though commenced more than one year after the discovery of the skin clip.

A recent decision of the District Court of Appeal, *Pellett v. Sonotone Corporation,* 55 A.C.A. 196, is another example of the court's tendency in this type of case to permit an action more than one year after the initial negligent act or omission occurs. The *Pellett* case involved an action against the defendant corporation and its agent, a dentist, who had made a plaster impression of the plaintiff's ear in order to properly fit plaintiff with a hearing device which the defendant corporation sold. In March, 1939, the dentist poured plaster into the plaintiff's ear allowing it to remain for a few minutes and then removing the resulting plaster impression. On his way home from the dentist's office, the plaintiff complained to another agent of the corporation that his ear hurt, but was informed that such pain was to be expected. Again, in October, 1939, the plaintiff complained to this same agent, but was told that the pain could be expected until he accustomed himself to wearing the hearing device. In February, 1940, the plaintiff consulted a physician in regard to his ear and was advised that there was a hard foreign substance in his ear which upon removal was ascertained to be bits of plaster and cotton which the defendants had negligently failed to remove at the time the plaster impression had been taken. In May, 1940 (one year and two months after the occurrence of the injury), the plaintiff commenced an action against the Sonotone Corporation and its agent, the dentist, who had taken the impression. The court held that this delay was no bar to the action and that it could be successfully prosecuted at such time, stating the rule to be that in an action to recover damages for negligently failing to remove from a human body a foreign substance which defendant had placed there, the *statute of limitations commenced to run from the date the plaintiff discovered, or from the use of reasonable diligence should have discovered, that the foreign substance had not been removed,* and the statute of limitations does not commence to run from the date the substance was placed in the human body. Although this action did not involve negligence on the part of a physician or a surgeon, the court applied the same rules as in the decisions above discussed.

Another fairly recent case, *Ehlen v. Burrows,* 51 Cal. App. (2d) 141, interpreted this extension of the statute of limitations as being applicable not only to a situation where some foreign matter is allowed to remain in the body but also to a case where a surgeon left broken roots in the jaw of a patient after removing several teeth. The court held that where it did not appear that the patient discovered the roots or should have discovered them more than one year prior to the commencement of the suit, her action to recover damages for the injuries sustained was not barred. On its facts, this case seems to extend the one year statute of limitations in all cases where a surgeon fails to remove some part of the human body which he has undertaken to remove by the operation performed. If this is true, then the one year statute will not commence to run in such cases until the patient discovers, or in the exercise of reasonable diligence should have discovered, the negligent omission of the surgeon.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 1, January, 1918

EXCERPTS FROM EDITORIAL NOTES

California Doctors in Service [January, 1918].—On another page of this issue of the JOURNAL appear the names of those physicians of California who have been commissioned in the government medical services. The list is incomplete and may contain inaccuracies. Partly to remedy these two faults, it is published. It is requested that each reader will particularly scrutinize it and report at once any omission or inaccuracy noted. The latest figures now available cover only through the early part of November. It is requested that all commissions accepted up to December 31, 1918, be reported at once if not already on this list.

The list is published, however, not solely for the sake of obtaining a corrected roll, but also for the more noble purpose of doing honor to those of our number who have been so fortunate as to receive commissions. Their honor is to some small extent reflected on us who stay behind for the time. We are proud of them and we are proud to belong to their profession. As they have gone and we stay behind, it behooves us to do our bit with a right good will that their sacrifice be not fruitless, that their exertions be not neutralized by lack of enthusiastic and effective support. From time to time, various avenues of home service have received comment in the JOURNAL. . . .

American Manufacture of Salvarsan.—The Federal Trade Commission has entered orders for the license of three firms to manufacture and sell salvarsan under the American name of "arsphenamine." The control of standards and quality of product will devolve upon the Federal Public Health Service. . . .

Periodic Physical Examination.—It is such an old story. Every doctor knows it. Most patients know it. But the trouble is that he and they are too busy to remember it. Both are prone to let well enough answer. No man can get himself in sufficient perspective to see his own beginning physical and mental infirmities. Few can do it for their moral shortcomings. Even the doctor himself does not always elicit the significant history of a little undue weariness, or slight breathlessness, or hazy vision, or inability to make physical and mental adjustments in reflex fashion. . . .

Every physician should preach and practice periodic medical examination, at least once yearly when in apparent health. It is reasonable, and represents the best development of the physician's art, the prevention of disease in the individual.

The Conservation of Vitamins.—With the present concern over food supply, comes the pitfall for both institutions and individuals of a dietary deficient in vitamins. We do not know what vitamins are. [Year, 1918.] The name is doubtless a misnomer. Accessory food substances necessary for growth and maintenance of healthy

(Continued in Back Advertising Section, Page 26)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"An extension of California's sterilization program, to include persons adjudged by courts to be psychopathic delinquents and sexual psycopaths, was recommended yesterday at a conference of heads of 16 State institutions, including Dr. G. Max Webster, director of Patton State Hospital. . . . The extension of the sterilization program would require specific legislation, said Dr. F. O. Butler, acting director of institutions, because the attorney general's office has held that the present sterilization program cannot legally include psychopathic delinquents or sexual psycopaths. 'There may be some public criticism of our action (in recommending extension of sterilization),' Dr. Butler said, 'but we must face it. Psychopathic and mentally-defective delinquents, and sexual psycopaths, should not be turned loose on society in their present state.'. . ." (San Bernardino *Sun,* Nov. 13, 1942.)

"Several weeks ago, the Napa City council advised the Napa County Medical Association that the $5-day rate and $10-night rate for examining drunk drivers was too high, and urged that the rate be reduced. This week, the physicians of the Victory Hospital staff announced to the council that the rates for examining drunk drivers have been set at $10 for calls from 6 a. m. until midnight, and at $12.50 for calls after midnight. The new rate is double the old rate for daytime and $2.50 more for night calls." (Napa *Journal,* Nov. 20, 1942.)

"Criticism of Dr. S. J. Francis, Santa Ana chiropractor, for stating publicly that the International Chiropractors Association had petitioned Major General Hershey to defer members of this profession, and permit them to serve on the home front, is not justified, Cash Asher, public relations director of the Association, said in Davenport, Iowa, today. Asher said that the Association had requested Hershey to recommend to draft boards the deferment of chiropractors, since there is no provision in the military establishment at this time for their services. He declared that Hershey had recommended to draft boards that osteopaths be deferred, because osteopathy, like chiropractic, is not included in the healing services of the Army or Navy. He added that, obviously, the same regulation should apply to chiropractors as applies to osteopaths. . . ." (Santa Ana *Register,* Nov. 9, 1942.)

"Justice of the Peace George DeWolf ruled today that defense witnesses in the trial of Grayson M. Martin, 59, of 315 First Street, charged with violating the State health code by selling sea water at $10 a gallon as a remedy for several major diseases, may testify whether they felt better after taking the preparation. . . . The State rested late yesterday after introducing the testimony of Henry Fliedmer, 622 South Eleventh Street, who went to the district attorney after buying one bottle,

(Continued in Back Advertising Section, Page 38)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.